



Medical & Personal Injury Lien Traps

RISK MANAGEMENT PRACTICE GUIDES
OF LAWYERS MUTUAL



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DISCLAIMER: This document is written for general information only. It presents some considerations that might be helpful in your practice. It is not intended as legal advice or opinion. It is not intended to establish a standard of care for the practice of law. There is no guarantee that following these guidelines will eliminate mistakes. Law offices have different needs and requirements. Individual cases demand individual treatment. Due diligence, reasonableness and discretion are always necessary. Sound risk management is encouraged in all aspects of practice.

INTRODUCTION

A great deal has changed since we at Lawyers Mutual last tackled the topic of medical and personal injury lien traps in North Carolina. Recent rulings concerning ERISA, Medicare, Medicaid, and State Employees Health Plan liens have shifted the entire approach an attorney should take when handling cases involving these particular players. A common inquiry we receive from our insureds is whether an attorney's disbursement duty lies with his client or a potentially valid lienholder when both parties demand disbursement. Before the recent flurry of lienholder friendly rulings, the standard advice we gave to our insureds was that their fees were generally shielded from personal injury liens and that their exposure was generally limited to any complaints that their client had against them. This meant that an attorney could virtually eliminate his potential exposure by: alerting the client to all potential liens, utilizing an employment contract that contemplated their eventual payment, complying with the Rules of Professional Conduct, and having the client sign an approval of all disbursements. While this advice should still be followed, it is no longer sufficient to shield an attorney from future claims.

Potential malpractice claims from a client are no longer an attorney's sole concern. Recent rulings have made an attorney's fee subject to disgorgement in favor of a valid lienholder's interest. Some have even gone as far as allowing an attorney and his client to become de facto collection agents for the lienholder. This means an attorney could be subject to malpractice claims from both the client and the lienholder if disbursement is not handled correctly. It is now more important than ever to perform a thorough analysis of whether you should take a personal injury case involving certain liens if the value is high enough to jeopardize your clients recovery. All

lienholders should be searched out and contacted before filing your case to ensure that you have the opportunity to negotiate with them while you still have leverage. You may regret taking the case if a previously unknown lienholder presents a valid lien after settlement. Once a settlement is finalized, all leverage is gone. Without a pre-arranged agreement with the lienholder, a case could result in a negative return for your efforts.

It is of utmost importance to research and stay abreast of new statutes and case law concerning personal injury liens because the landscape is constantly changing. This manuscript is not intended to be a complete treatment of the topic.

The following is a list of the liens that will be addressed in this manuscript. Each lien requires a different legal approach.

- **ERISA Health Plans:** 29 U.S.C. 20 § 1001 *et seq.* & *Sereboff*, 547 U.S. 356 (2006)
- **Medicaid:** N.C.G.S. § 108A-57 & 42 U.S.C. § 1396p(a)(1)
- **Medicare:** 42 U.S.C. § 1395(b)(2)(A)
- **Teachers' and State Employees' Health Plan, Cost Plus Plans & NC Health Choice Plan:** N.C. Gen. Stat. § 135-40.13, N.C. Gen. Stat. § 108A-57(c) & N.C. Gen. Stat. § 58-65-135
- **Health Care Providers:** N.C.G.S. §§ 44-49, 50
- **N.C. Workers' Compensation:** N.C.G.S. § 97-10.2
- **U.S. Workers' Compensation:** 5 U.S.C. § 8132
- **TRICARE:** 10 U.S.C. § 1095
- **Vocational Rehabilitation:** N.C.G.S. § 143-547
- **Ambulance Service Liens:** N.C.G.S. § 44-51.8

LIENS ON PERSONAL INJURY SETTLEMENTS

THE SPECIAL CASE OF ERISA

The Employment Retirement Income Security Act of 1974¹ allows employers to establish self-funded health care and disability plans that are not subject to state insurance regulations or other state interference. If the applicable state has a law or rule limiting subrogation rights, such laws are abrogated by ERISA, which preempts the field. Employers who provide benefits to their employees through a qualified, self-funded ERISA plan may seek reimbursement or subrogation, but it is not required.

Creation of an ERISA “Lien”

While virtually all ERISA plans are sufficient to assert a lien, an ERISA claim is not automatically deemed to have a lien. As a result, repayment of ERISA’s claim for reimbursement is not always automatic. However, ERISA plans can create a contract-based lien called an *equitable lien by agreement* if it contains the appropriate language.² The Plan’s language is sufficient to create an *equitable lien* if the Plan identifies: (1) a *particular fund* (separate from the beneficiary’s general assets) to which the Plan is entitled to recovery; and (2) a *particular share* of the damages to which the Plan is entitled.³ This is not a particularly high standard. Language indicating that a Plan is entitled to reimbursement for all medical expenses paid on the beneficiary’s behalf from any settlements, judgments, or other means of compensation related to those expenses is sufficient.

Determining if an ERISA Lien Exists

To determine if an ERISA plan has a valid claim, an attorney facing a reimbursement/subrogation claim must insist on reviewing all of the pertinent documents

including the IRS Form 5500, the Summary Plan Description (SPD), and the underlying plan language. The IRS Form 5500 can be found at www.freerisa.com. You can find a sample request for plan documents and sample Form 5500 in this manuscript’s addendum . Once you have the IRS Form 5500, direct your attention to Line 9a that specifies the plan’s funding arrangement. If only the box number 1, “Insurance”, is selected, the plan may be out of luck and you may be home free. North Carolina’s anti-subrogation regulation prohibits the fully insured plan from seeking reimbursement.⁴ The Court of Appeals has upheld this regulation.⁵ Virginia also prevents subrogation provisions in health insurance contracts.⁶

If box numbers 2, 3, or 4 are selected on the Form 5500, the plan is likely self-funded and thereby entitled to reimbursement. Even though this may be the case and the plan demands reimbursement in its correspondence to your office, do not automatically assume that the plan language calls for reimbursement. Read the plan language fully to determine if a reimbursement provision exists. If there is a reimbursement provision, what does it say? An attorney should examine the potential sources from which the plan seeks recovery – tortfeasor, uninsured motorist carrier, underinsured motorist carrier, medical payments, etc. – to see if the provision actually affects the client. What if the SPD language differs from the Plan language? According to the Supreme Court case *Cigna Corp. v. Amara*, the terms of the SPD alone do not dictate the terms of the plan and do not qualify for enforcement under ERISA.⁷ After *Cigna*, the plan itself must set forth the Plan’s right of subrogation/reimbursement, and that right must further be set forth in the SPD. If the language is insufficient in either instrument, one may be able to avoid the claim. Note that the plan terms at the time of the injury need to be examined.

1 29 U.S.C. 20 § 1001 *et seq.*

2 *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).

3 *The Boeing Co. v. Thurmon*, 2009 U.S. Dist. LEXIS 113693 (E.D.Mo. December 7, 2009).

4 11 N.C.A.C. 12.0319.

5 *In The Matter Of: A Declaratory Ruling By The North Carolina Commissioner Of Insurance Regarding 11 N.C.A.C. 12.0319*, 134 N.C. App. 22, 517 S.E.2d 134 (1999).

6 Virginia Code § 38.2-3405.

7 *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011).

Power of an ERISA Lien: No Equitable Defenses

According to the recent ruling by the Supreme Court in *US Airways, Inc. v. McCutchen*, if an equitable lien is created by the agreement, the agreement's language controls absolutely, even to the exclusion of the common law principles of unjust enrichment, the make-whole doctrine, and the common-fund rule.⁸ It is now settled that ERISA *equitable liens* are not subject to equitable defenses and that Plans are to enjoy the benefit of their bargain. The Court held that the terms of an ERISA plan, not equitable principles such as unjust enrichment, control the plan's ability to enforce an equitable lien, even if the enforcement of a lien would result in a net loss for the beneficiary's litigation efforts.⁹ However, if a Plan is silent on an issue, common law principles apply to that particular issue. If it is silent concerning the parties' share of the costs of recovery, the common-fund doctrine requires the Plan to share in the attorneys' fees and other costs associated with recovery. If the Plan states that it will not share in the costs of recovery, the Plan's language controls, and the beneficiary is solely responsible.

There are additional circumstances that may create an enforceable right of reimbursement where the Plan's language was insufficient to do so. This can occur when an attorney represents to the ERISA plan provider that the provider's claim will be 'protected' or the attorney otherwise misleads the plan provider.¹⁰ The attorney should avoid signing any letter, agreement or other document that binds her to represent the plan's interests. If a right of reimbursement is created in this manner and the Plan is not made whole, disgorgement of the attorneys' fees is a very likely source of recovery.

Reach of an ERISA Lien: Funds in Control of (or for the Benefit of) the Beneficiary

The power of recovery for an ERISA claim was first defined by the Supreme Court in *Great West Life v. Knudson*.¹¹ In *Knudson*, the Court held that the only remedy available to a plan was an equitable remedy and that ERISA plans could not pursue a suit for money damages. Appropriate equitable relief includes, but is not limited to, an injunction to prevent the attorney or liability

carrier from disbursing funds subject to the Plan's claim. It also includes the imposition of a constructive trust on identifiable funds.

In *Sereboff v. Mid Atlantic Medical Servs., Inc.* (MAMSI), the Supreme Court expounded upon the reach of an ERISA lien when it held that strict traceability requirements were not applicable to an *equitable lien* in the same way they apply to *equitable restitution*.¹² The court allowed MAMSI to recover from funds that had been disbursed and were in the beneficiaries' investment accounts. The *Sereboff* ruling did not clarify whether the funds had to be in possession of the beneficiary to be recoverable by an equitable lien.

Most recently, the question of whether settlement funds in a third-party's possession are recoverable by joining the third-party as a defendant in the suit was clarified in *ACS Recovery Servs. v. Griffin*.¹³ The 5th Circuit Court sitting *En Banc* reversed the lower court's holding that a Plan could not sue the Special Needs Trust although the lower court's holding was consistent with 5th Circuit precedent. The court's reasoning was that The Plan held an *equitable lien* on the settlement that attached at the time the case was settled, which allowed the imposition of a constructive trust, even though the funds were never in the beneficiary's possession. The court cited *Bombardier v. Ferrer* in the decision: "The Supreme Court's conclusion is that § 502(a)(3) admits of no limit (aside from the 'appropriate equitable relief caveat') on the universe of possible defendants, and therefore authorizes a cause of action against a non-fiduciary, non-party in interest' ... [who] holds disputed settlement funds on behalf of a plan-participant."¹⁴

Here are some additional examples of other circuits embracing the idea that a third-party is reachable by a constructive trust created by an ERISA *equitable lien*. In one case, a constructive trust was imposed on a husband and trustee of his wife's special needs trust.¹⁵ In another, a constructive trust was imposed on a conservator acting as a trustee for a special needs trust.¹⁶ In each of these cases and *Longaberger v. Kolt, infra.*,¹⁷ the courts held that, according to *Sereboff*, an equitable lien for reimbursement attached to settlement proceeds as soon as a settlement fund arises from the injuries requiring plan payments.

⁸ *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013).

⁹ *Id.* at 1551.

¹⁰ *Great West Life & Annuity Ins. Co. v. Bullock*, 202 F.Supp.2d 461, 464-65 (E.D.N.C. 2002).

¹¹ *Great West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

¹² In *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 547 U.S. 356 (2006).

¹³ *ACS Recovery Servs. v. Griffin*, 2013 U.S. App. LEXIS 9324, 3-4, 2013 WL 1890258 (5th Cir. Tex. May 7, 2013).

¹⁴ *Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5th Cir. 2003).

¹⁵ *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007).

¹⁶ *Admin Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Wealth Plan v. Horton*, 513 F.3d 1223 (11th Cir. 2008).

¹⁷ *Longaberger v. Kolt*, 586 F.3d 459 (6th Cir. 2009).

Reach of an ERISA Lien: Against an Attorney

In North Carolina, the courts have historically been favorable to attorneys facing an ERISA Plan's claim for reimbursement.¹⁸ However, this comfort wears thin when considering the recent willingness of the 5th Circuit to overturn significant case law in the *ACS v. Griffin* ruling (special needs trust outside of beneficiaries control accessible by ERISA lien). In addition, these favorable rulings only apply if an attorney is lucky enough to be sued in North Carolina. Unfortunately, a Plan may bring an action for reimbursement in the district court where the plan is administered, even if the participant or beneficiary lacks minimum contacts with the state in which the district is found.¹⁹

Several other circuits have ruled it lawful to impose constructive trusts upon settlement proceeds in possession of third parties based upon an *equitable lien by agreement*. The most pertinent case for an attorney to consider is *Longaberger v. Kolt*, in which a tort lawyer was forced to disgorge his fee that had already been collected and spent because he chose to disregard the Plan's first priority lien and commingle the settlement funds with his own.²⁰ In the 4th circuit, the most recent favorable case concerning the issue of attorneys' fees and ERISA liens is *T.A. Loving Co. v. Denton*.²¹ *Denton* relied on the *Bullock Rule*²² to prevent an ERISA fund from disgorging an attorney of his fees to satisfy an equitable lien. *Denton's* weakness moving forward is that the *Bullock Rule* will not control in the wake of *CGI Techs. & Solutions, Inc. v. Rose*.²³ An attorney should scrutinize current case law thoroughly before relying upon *Denton*.

In *CGI v. Rose*, the Supreme Court vacated the 9th Circuit's judgment and remanded the case for further consideration in light of the recent ruling in *US Airways, Inc. v. McCutchen*.²⁴ CGI filed a suit to recover its expenditures against the beneficiary and his attorney, who refused to disburse the funds according to the Plan's terms and, instead, reserved the funds in a trust account until the claim was resolved. The two circuit court holdings that the Supreme Court vacated were: (1) that the beneficiary's attorney should be dismissed as a defendant in the case; and (2) that the Plan's language was subject to equitable defenses, despite sufficient language to entitle the plan to full recovery

and remove liability for recovery costs. The Supreme Court's decision to grant certiorari to *CGI v. Rose* simply to vacate and remand with instructions that *McCutchen* controls indicates that all future ERISA suits concerning the following issues will be absolutely governed by the Plan terms: (1) whether an attorney can be a party to an ERISA reimbursement suit; (2) whether a Plan's reimbursement must be reduced by a share of the costs of recovery; and (3) whether the Plan is entitled to full recovery even if the end result is the Plan free-riding on the efforts of the beneficiary and the attorney to their detriment.

An Attorney's Strategy

The Plan's ability to reach into a client's post-disbursement pocket for relief and the Plan's ability to assert a first priority lien position requires an attorney to be extremely cautious and forward thinking with respect to potential ERISA liens. Also, reach out for help if you feel like the claim may be too complex. There is potential that a client could go without reward and the Plan could absorb the entire settlement amount despite successful litigation efforts. To quote *McCutchen*, "To be sure, the plan's allocation formula—first claim on the recovery goes to US Airways—might operate on every dollar received from a third party, even those covering the beneficiary's litigation costs." This would most assuredly result in a suit for malpractice. Accordingly, the following are steps the prudent attorney should take to safeguard against such a circumstance.

1. If you are reasonably sure that the case involves a self-funded ERISA plan, consider whether taking the case is a good idea. If you have a case with questionable liability and high medicals, you might find yourself working for the ERISA Plan at the end of the day. If you are inclined to take the case, consider working out a suitable allocation of settlement or judgment with the ERISA Plan as a condition to your taking the case. At this point, you have some leverage with the Plan that you will not have if you wait until the settlement funds are in your trust account. Also, avoid signing or allowing your client to sign a reimbursement agreement or anything that may allow Plan to

18 See *infra*. *T.A. Loving Co. v. Denton*, 723 F. Supp. 2d 837 (E.D.N.C. 2010) and *Great West Life & Annuity Ins. Co. v. Bullock*, 202 F.Supp.2d 461, 464-65 (E.D.N.C. 2002).

19 *United Health Group, Inc. v. Mesa*, 2007 WL 2872382 (U.S.D.C.D. Minnesota).

20 *Longaberger v. Kolt*, 586 F.3d 459 (6th Cir. 2009).

21 *T.A. Loving Co. v. Denton*, 723 F. Supp. 2d 837 (E.D.N.C. 2010).

22 *Great West Life & Annuity Ins. Co. v. Bullock*, 202 F.Supp.2d 461, 464-65 (E.D.N.C. 2002) (attorney is only liable where the attorney was a party to the plan, the attorney agreed to abide by plan provisions, or the attorney's wrongdoing or intentional effort enabled the beneficiary to avoid plan provision).

23 *CGI Techs. & Solutions, Inc. v. Rose*, 683 F.3d 1113 (9th Cir. 2012) *rev'd* 2013 U.S. LEXIS 3201 (U.S.).

24 *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013).

claim you were representing their interest in the suit. Do not talk to the Plan without your client's consent to negotiate. However, see RPC 170 (*A lawyer may jointly represent a personal injury victim and the medical insurance carrier that holds a subrogation agreement with the victim provided that the victim consents and the lawyer withdraws upon development of actual conflict of interest.*)

2. Perform adequate due diligence. Scrutinize the entire Plan, particularly the reimbursement clause to determine whether the plan is self-funded and, most importantly, the scope of the *equitable lien* if there is one. If it is self-funded, even if there is a stop-loss agreement, the Plan documents govern. If fully insured, NC's anti-subrogation statute should apply. Find out the precise terms of the reimbursement provisions, if any. (www.freecerisa.com).
3. Have a heart-to-heart with the client after considering the Rules of Professional Conduct, ethics opinions and case law. If in your judgment, the Rules, ethics opinions, and case law do not obligate you to protect ERISA's reimbursement claim, give the client options.
4. Decide whether a strategy exists to not make a claim in your pleadings for repayment of medical expenses and other items to which the ERISA plan's reimbursement clause lays claim and whether you should implement it. Most plans will have sufficient language to prevent this strategy's success, but it is a possibility that should be considered.
5. If an *equitable lien* exists and no strategy exists to subvert it, encourage the client to reach an agreement with the ERISA Plan about how any recovery will be allocated while you still have leverage (before the suit begins or settlement is finalized).
6. If the client wants you to talk to the Plan, formally request the plan documents and talk to the Plan. Also, request the statement of all charges from the Plan and review it for charges unrelated to the negligence of the defendant. Negotiate with the Plan.
7. Do not accept checks with the Plan's name on it. Confession of judgment is an option if the insurance company will not cooperate.
8. Consider mailing your trust account check to the plan and advising the plan the check is for

payment in full and complete satisfaction of the claim. Tell the Plan to return the check within 10 days if this is not acceptable so you can cancel the check and write a check to your client.

9. If a settlement is not reached with ERISA and the client demands disbursement or the Plan asserts an interest before disbursement, it may be appropriate to request an interpleader and have the court sort out the ethical issues of disbursement separately.

MEDICAID

Medicaid is a "welfare" program administered by the State of North Carolina. Eligibility depends on such factors as income level, available financial resources, and other criteria. Generally, health care providers are not required to accept Medicaid patients. However, if they accept Medicaid patients, they must accept Medicaid payments in full, except for certain specific services for which a co-payment may be charged. If a provider itemized the charges for a particular course of treatment and submitted only some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items. The lien is created by N.C. Gen. Stat. § 108A-57 and is not limited to the \$4,500 cap on recovery from wrongful death settlements set forth in N.C.G.S. §28A-18.²⁵ Medicaid has a lien on payments made by or from any of the following sources: (1) Uninsured and Underinsured Motorist Coverage; (2) Medical Payments Coverage; (3) Liability Insurance; and (4) Workers' Compensation Insurance.

Creation & Characteristics of a Medicaid Lien

Medicaid has a lien on any settlement or recovery that is related to services for which Medicaid has paid. Medicaid is not required to share in attorneys' fees or recovery costs. Medicaid's lien is perfected upon the Medicaid recipient's acceptance of benefits and his or her assignment of rights to Medicaid. Actual notice of a Medicaid lien is not required; constructive notice is sufficient.²⁶ "Constructive notice" includes, but is not limited to, an attorney's receipt of a medical bill that references Medicaid filing or payment. This requires an attorney to be on high alert for any potential Medicaid liens to avoid potential malpractice claims from Medicaid. In most cases, you will have to determine lien priority

²⁵ See, *Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997).

²⁶ *Johnston County v. McCormick*, 65 N.C. App. 63, 308 S.E.2d 872 (1983).

amongst multiple liens. Here is how Medicaid interacts with other liens:

Medicare vs. Medicaid: Medicare liens have priority over Medicaid liens in tort settlements and Medicare will not pro-rate with Medicaid. So if the Medicare lien is greater than the portion of the settlement allotted for medical expenses, Medicaid cannot make any recovery. If the Medicare lien is less than the total allotted for medical expenses, Medicaid can recover the difference.

Medicaid v. Medical Provider Liens (N.C.G.S. §§44-49, 44-50): Medicaid must pro-rate with other medical providers with unpaid bills related to the action, pursuant to N.C.G.S. §108A-57.

Medicaid's recovery has historically been limited to one-third of the settlement amount under N.C.G.S. §108A-57, which also mandated the reserve of one-third of all settlement funds for medical liens irrespective of the portion of the settlement actually assigned to medical expenses. However, Medicaid's lien is now limited to the portion of a settlement that is designated for medical expenses. In the case of *Wos v. E. M. A.*,²⁷ the U.S. Supreme Court held that N.C. Gen. Stat. § 108A-57 is preempted by the anti-lien provision of the Medicaid Act.²⁸ As a result, the state statute's requirement that one-third of all personal injury awards must be reserved for Medicaid liens is no longer valid. The Medicaid lien limitation rule from *Department of Health and Human Services v. Ahlborn*²⁹ now applies. In *Ahlborn*, the Supreme Court held that federal law limited Medicaid's lien to the amount of the settlement attributable to the recovery of medical expenses.

A practical implication of *Wos* is that settlements are now much more susceptible to separate proceedings solely for the purpose of determining Medicaid's share. Any lump-sum settlement that doesn't specifically define what portion of the award is for medical expenses is subject to suit. It isn't clear whether the N.C. Supreme Court's decision in *Andrews v. Haygood*³⁰ will continue to bar the use of *Ahlborn*'s pro-ration principles. If *Ahlborn*'s pro-ration principles are eventually ruled to apply, the amount of Medicaid's recoveries could be significantly reduced in most cases.³¹

Procedure for Handling Medicaid Liens

Accordingly, we suggest you take the following steps when pursuing a personal injury case where Medicaid is a potential lienholder:

1. Be on high alert for Medicaid liens.
2. Provide timely written notification to the government agency.
3. Audit the statement that Medicaid sends you.
4. Make a tactical decision whether to seek recovery for medical costs and state that intent in the pleadings.
5. Seek to negotiate an agreement concerning the equitable apportionment of medical expenses in the settlement.
6. If no settlement is reached, seek for a court order declaring the percentages of the settlement by category.
7. Be prepared to argue that the agency's claimed amount of reimbursement is invalid considering *Ahlborn* and *Wos*.³²

If you suspect that Medicaid has paid any medical or hospital bill for your client, review all medical and hospital billings and charge statements to determine if a Medicaid submission was made or Medicaid benefits were received. Write to the North Carolina Department of Human Resources, Third-Party Recovery Section, to determine if there is a lien. The Third-Party Recovery Section will send you a written statement of its payments. Do not automatically assume this statement is correct. Like Medicare, Medicaid's statement shows all charges they paid from the date of the accident until the date of the request, using best efforts to determine related charges. You need to compare Medicaid's claim against the accident-related bills and advise Medicaid of any unrelated payments. Simply review Medicaid's statement and flag or otherwise indicate the payments that are unrelated to the accident. Mail your "audited copy" of the statement back to the Third-Party Recovery Section. Medicaid is very understanding of contested payments. Keep in mind that if a provider itemized charges for a particular course of treatment and only submitted some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items.

²⁷ *Wos v. E. M. A.*, 133 S. Ct. 1391 (2013).

²⁸ 42 U.S.C. § 1396p(a)(1).

²⁹ *Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (2006).

³⁰ *Andrews v. Haygood*, 362 NC 599 (2008).

³¹ See NORTH CAROLINA PERSONAL INJURY LIENS MANUAL 180,83 (2nd ed. 2011).

³² Memo. from Lou Bograd, Counsel at Center for Constitutional Litigation, Possible Extension of Ahlborn Ruling to Medicare and Guidance to Plaintiffs' Counsel Regarding the Decision 5-6, (2006).

MEDICARE

Medicare is a federal program available to those who are in four basic groups: (1) persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits; (2) disabled persons of any age who have received Social Security, widows or Railroad disability benefits for 25 months; (3) persons with end-stage renal disease (“ESRD”) who require dialysis treatment or a kidney transplant; and (4) persons over age 65 who are not eligible for either Social Security or Railroad Retirement benefits who purchase Medicare coverage by payment of a monthly premium. There are four types of Medicare plans available: Parts A, B, C, and D. Parts A and B are administered by Medicare directly, through the Centers for Medicare and Medicaid Services (CMS). These plans are certain to have an enforceable lien. Parts C and D allow private insurance companies to provide health insurance (Part C) and prescription drug (Part D) plans through contracts with the government. These plans are commonly referred to as “Medical Advantage Plans” (MAP) and they are not administered through the government. Accordingly, it is important to clarify what type of Medicare plan the client carries, so that the claims procedure can be properly directed at the Medical Advantage Organization (MAO) if the client carries Part C or D. While it is still somewhat unsettled as to whether an MAO has the right to assert a claim, the trend appears to be that they do.³³ As a result, a case involving a Medical Advantage Plan should be treated as if it has a valid lien claim. The same procedures should be followed as if the coverage were provided under a Part A or Part B plan.

Creation of a Medicare Lien

Medicare is a “secondary payer” with respect to medical expenses incurred due to an injury that was caused by the negligence of another. Medicare’s payments are “conditional payments,” and Medicare makes these payments on the condition that they will be repaid once payment is received from the “primary payer.” Such primary payers include liability insurance, self-insurance,

medical payments, uninsured motorist coverage, and underinsured motorists coverage. Being a secondary payer, Medicare is entitled to assert its rights to reimbursement for those payments in the form of a lien authorized by the Medicare Secondary Payer Act.³⁴ Federal regulation requires that payment be sent to Medicare within 60 days of a personal injury settlement.³⁵ Notice is not required for Medicare to assert a lien;³⁶ its lien is typically in first position;³⁷ and the lien can be asserted against the attorney’s earned fees.³⁸ This provides the ultimate incentive for an attorney to determine whether a client is a Medicare beneficiary in their intake form.

Procedure for Handling a Medicare Lien

If the client is determined to be a Medicare beneficiary, the claim should immediately be set up with Medicare. Doing this early in the process will provide the necessary time before settlement to work out any disagreements with Medicare over the correct amount of their reimbursement claim. Waiting until settlement is imminent will only complicate and delay settlement of the case.

Plaintiffs’ lawyers are all too familiar with dealing with Medicare liens. Perhaps the only positive is that Medicare shares in the costs of recovery and attorney fees.³⁹ That is, unless the source is medical payments coverage under an automobile or home insurance policy, in which case they do not share in the costs or fees. The process is usually an arduous one that requires a deeper level of familiarity with the CMS and MAO administration systems than this manuscript attempts to address. The basic process involves: (1) setting up the client’s claim; (2) receipt of and response to the rights and responsibilities letter from Medicare which outlines what they will need to complete the recovery process; (3) sending Medicare a proof of representation letter; (4) receipt, review, and disputing of the conditional payment letter (CPL), which itemizes all the payments Medicare believes they made in connection with the injury settlement; (5) notifying Medicare of a final settlement; (6) obtaining a final demand letter; (7) disbursing the funds appropriately; and (8) obtaining the clearance letter.

³³ *In re Avandia Mktg.*, 685 F.3d 353 (2012).

³⁴ 42 USC § 1395y(b)(2)(B)(ii).

³⁵ 42 C.F.R. 411.25(h).

³⁶ 42 C.F.R. 411.21.

³⁷ 42 U.S.C. § 1395y(b) (Supp. 1998).

³⁸ 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. 24(2)(g).

³⁹ C.F.R. § 411.37(a).

Alternative Resolution Methods

In addition to those steps, which assume a fairly routine process, alternative resolution methods may be favorable for your client. This is particularly true if the Medicare lien threatens to absorb all of the client's settlement proceeds, which it legally has the right to do.⁴⁰

A party can seek a reduction in the lien by a **Pre-Settlement Compromise**, which is allowed by the Federal Claims Collection Act (FCCA) of 1966 in the event that: (1) the cost of collection does not justify enforcement of collection of the full claim; (2) there is an inability to pay within a reasonable time by the individual against whom the claim is made; or (3) the chances of successful litigation are questionable, making a settlement compromise advisable.⁴¹ In a "contributory negligence" state like North Carolina, the chances of Medicare foregoing recovery are real and use of this approach is encouraged.

A complete **Waiver** may also be sought if a beneficiary is without fault and adjustment or recovery would either: (1) defeat the purpose of Title II or Title XVII of the Act; or (2) be against equity or good conscience. Waivers usually only occur post-settlement.⁴²

When the settlement is \$25,000 or less, another option is the **Self-Calculated Conditional Payment Option** if the following conditions are met: (1) the claim was originally submitted to the Coordination of Benefits Contractor (COBC); (2) the liability insurance (including self-insurance) settlement will be for a physical trauma based injury; (3) the total settlement does not exceed \$25,000; and (4) the date of the accident must have occurred at least six months prior to the request for conditional payment information.⁴³

For even smaller settlements, \$5,000 or less, another option is the **Fixed Percentage Option** if: (1) the settlement total is less than \$5,000; and (2) the settlement involves physical, trauma-based liability insurance (including self-insurance). Under this option, Medicare will accept 25% of the gross settlement (no reduction for attorney fees) as payment in full, regardless of the amount paid in by Medicare on the beneficiary's behalf.⁴⁴

If none of the alternative resolution methods result in a favorable outcome, the appeals process may be undertaken. Appeals begin with reconsideration by the examiner. If the examiner denies the appeal, the claim then goes through a qualified independent contractor, then an administrative law judge, then the Medicare Appeals Council, and ultimately the district court. The appeal must be filed within 120 days of the final demand letter, and the failure to properly follow the administrative process may result in the forfeiture of the claim.⁴⁵

Changes to Medicare Administration: The SMART Act

The administrative process is going through an overhaul. The Strengthening Medicare and Repaying Taxpayers, or SMART Act,⁴⁶ is set to go in effect on October 10, 2013. Some of the changes, like online conditional payment information, have already been implemented. Some of the many of the changes are: (1) up-to-date conditional payment information will be available online; (2) establishing conditional payment exposure prior to settlement; (3) a minimum settlement value to which Medicare liens will attach, which will be set annually; and (4) a three year Statute of Limitation for the government to bring suit from the day a judgment is entered or settlement is reached. There are many more changes the SMART Act is imposing on Medicare reimbursements and compliance, so be sure to familiarize yourself with all of the changes before October 10, 2013.

Medicare Set-Asides: Worker's Compensation

It is important to note that in certain worker's compensation cases, where the worker's compensation plan covers future medical payments and the judgment or settlement is partially for those payments, Medicare will require a set-aside of those funds. Since Medicare is a secondary payer, they will not pay for any future medical expenses until the set-aside has been exhausted. For guidance on the proper handling of Medicare set-asides, an attorney should consult the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference.⁴⁷

40 C.F.R. § 411.37(d).

41 31 U.S.C. § 3711.

42 42 U.S.C. § 1395gg.

43 Medicare Secondary Payer Recovery Contractor, Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement, at 2, www.msprc.info/forms/SelfCalculatedFinalCP.pdf (last visited June 26, 2013).

44 Medicare Secondary Payer Recovery Contractor, Fixed Percentage Option, www.msprc.info/forms/Fixed%20Percentage%20Option%20Information.pdf (last visited June 26, 2013).

45 Center for Medicare and Medicaid Services, Appeals Process Flowchart, www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/AppealsProcessFlowchart-FFS.pdf (last visited June 26, 2013).

46 112 P.L. 242, 126 Stat. 2374, 2013 Enacted H.R. 1845, 112 Enacted H.R. 1845.

47 Center for Medicare and Medicaid Services, Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/March-29-2013-WCMSA-Reference-Guide-Version-13-copy.pdf (last visited June 26, 2013).

TEACHERS' AND STATE EMPLOYEES' HEALTH PLAN, COST PLUS PLANS & NC HEALTH CHOICE PLAN

This lien was recently revamped by the state legislature in and is now established by the code in N.C.G.S. § 135-48.37(c). It was originally created in 2004 by N.C.G.S. § 135-40.13A, which was succeeded by N.C.G.S. § 135-45.15. In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion.⁴⁸ There is a presumption that a 33 1/3% attorneys' fee is reasonable. The Plan's lien recovery is not subject to the wrongful death statute's \$4,500.00 cap on payment of medical expenses.⁴⁹ Similar to workers' compensation carriers, the Plan has the right to pursue recovery directly against a third party in the event the Plan member does not pursue a claim.⁵⁰ The entity you will be engaged with regarding a Plan's claim or lien is the Public Consulting Group, Inc.⁵¹

In determining whether the Plan has a lien against your client's recovery you must first assess the source of the recovery. The deciding factor is whether the proceeds at issue are first party proceeds or third party proceeds. Only recoveries from "liable third parties" are subject to a lien by the Plan. Examples of third party coverage include: liability proceeds of all types (ex: auto, homeowners', and professional liability). Examples of first party coverage include the following: workers compensation, medical payments, underinsured motorist coverage, and uninsured motorist coverage.

A SEHP lien has been regarded as a "super-lien" because of the authority given to its rights of recovery by the legislature and courts. There is no requirement for the lien to be perfected. No actual notice is required for the lien to exist. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney.⁵² According to the enacting statute and the first impression case of *The State Health Plan for Teachers and State Employees v. Barnett*, an attorney has an affirmative statutory duty to disburse lien proceeds to SEHP.⁵³ In *Barnett*, the attorney was held personally liable for the entire SEHP lien that totaled \$28,000 because of his

failure to disburse to the Plan. This is despite the fact that his earned fee was only \$14,000. The attorney disbursed the settlement funds to his client pursuant to a client directive that contained an agreement to release him from future actions. The court held that an attorney cannot ignore a valid SEHP lien when disbursing settlement funds, regardless of his client's wishes.

SEHP Liens Interaction with Other Liens

The Plan claims a first priority right to any funds the Plan member recovers. This is in conflict with federal liens (ex: Medicare, TRICARE, U.S. Workers' Compensation). It is uncertain what the order of lien prioritization should be. The Plan's lien, however, would appear to take priority over healthcare provider liens. An attorney is best advised to notify all parties that hold liens on the settlement and to seek a workout amongst all parties to avoid additional litigation. A best practice would be to get all lienholders to agree to full satisfaction in the settlement agreement. In *Barnett*, SEHP was awarded 50% of the client's proceeds (\$14,000), even though only \$9,386 was allocated to medical expenses.⁵⁴ The holding appears to indicate that SEHP's lien may operate both separately from and in addition to other valid liens. This makes it of the utmost importance to try to settle with SEHP and other lienholders to limit the possibility of 100% absorption of the client's fees.

Cost Plus Plans

Cost Plus derive its authority from N.C. Gen. Stat. §58-65-135 and typically cover local or county employees. Cost Plus plans are distinct and separate from all other plans, including the State Employees Health Plan and ERISA. This is an important fact, because practitioners often confuse the Cost Plus plan for either a SEHP or ERISA plan. The enacting statute does not specifically authorize a lien in favor of Cost Plus plans. In addition, there is no case law as of today that addresses the issue of the Plan's reimbursement rights. The enacting statute states that "the administration of any Cost Plus plans as herein provided shall not be subject to regulation or supervision by the Commissioner of Insurance."⁵⁵ The

48 N.C.G.S. § 135-48.37(d).

49 N.C.G.S. § 135-48.37(a).

50 N.C.G.S. § 135-48.37(b).

51 See www.PublicConsultingGroup.com.

52 N.C.G.S. § 135-48.37(d).

53 *The State Health Plan for Teachers and State Employees v. Barnett*, NO. COA12-999 (N.C. Ct. App. May 7, 2013).

54 *Id.*

55 N.C.G.S. §58-65-135.

result is that the Plan will argue that anti-subrogation rules do not apply to the Plan since its administration is outside of the commissioner's reach. However, your client's argument should be that the word "administration" does not apply to anything other than the daily administrative activities and that subrogation activity is outside of the normal scope of plan administration. While it is unclear whether Cost Plus Plans have valid subrogation and reimbursement rights, it is virtually certain that an attorney has no duty to protect the Plan's interest if it were to assert a lien on your client's settlement funds.

NC Health Choice for Children Plans

NC Health Choice Plans were instituted by the state legislature to provide free or reduced coverage for children within the state whose parents' income is too high for Medicaid and too low for private insurance. Although it is administered by the same entity as the State Employees Health Plan, the lien is separate and distinct. There was not a statutory lien until April 23, 2009 when the state legislature passed an amendment to N.C. Gen. Stat. § 108A-57(c) to include NC Health Choice plans, which gives NC Health Choice the same reimbursement rights as Medicaid. Accordingly, you should refer to the Medicaid section of this manuscript to determine how to proceed when representing a client whose medical bills were paid by a NC Health Choice plan. While there is not a specific effective date declared, an attorney should presume the statute to apply to payments made by NC Health Choice from April 23, 2009 forward.

HEALTH CARE PROVIDERS

Health Care Provider Liens are statutorily created by N.C. Gen. Stat. §§ 44-49, 44-50. These statutes create a lien "in favor of any person, corporation, State entity, municipal corporation, or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital attention, or hospital attention or services rendered in connection with the injury in compensation for which the damages have been recovered." There are certain services, such as chiropractic

services, which the statute does not definitively create a lien in favor of. However, these services may obtain a functional equivalent of a Health Care Provider Lien by obtaining a lien by assignment.⁵⁶

Chiropractor Tactics: A Recent Trend

A new tactic that we have seen with increased frequency at Lawyers Mutual is a chiropractor attempting to insert a "U.C.C. lien" into service contracts to increase their odds of collection in the absence of a perfected lien under N.C.G.S. §§ 44-49, 44-50. We have successfully defended such cases, and the result has been a flat dismissal at the magistrate level without an appeal. We believe that health care provider liens are governed specifically by N.C.G.S. §§ 44-49, 44-50. Our stance is that the specific tailoring of this statute along with its omission of chiropractic services preempts any concessions purportedly provided by the general code included in Chapter 9 of the U.C.C., which provides that the article "does not apply to the extent that ... another statute of this State expressly governs the creation, perfection, priority, or enforcement of a security interest created by this State[.]"⁵⁷ In addition, the same article states that it does not apply to "an assignment of a right to payment under a contract to an assignee that is also obligated to perform under the contract."⁵⁸ Please contact us if you are confronted with a similar assertion by a chiropractor's counsel. We may be able to find a successful resolution of the situation.

Lien Creation: No Attorney Representation

In *Charlotte-Mecklenburg Hospital Authority v. First of Georgia Insurance Company et al.*,⁵⁹ the North Carolina Supreme Court recognized, in a case where the patient was not represented by counsel, that a valid lien was created by a healthcare provider against proceeds in the hands of the liability carrier. The lien was "created" because the injured victim signed an assignment of the proceeds of a personal injury action and the liability carrier was put on notice of such an assignment. *First of Georgia* could also be construed to mean an assignment creates a valid lien against the proceeds in the hands of UM and UIM carriers, in cases where no attorney is involved in distributing the proceeds.

⁵⁶ *Alaimo Family Chiropractic v. Allstate Ins. Co.*, 155 N.C. App. 194, 574 S.E.2d 496 (N.C. Ct. App. 2002).

⁵⁷ U.C.C. § 9-109(c)(2).

⁵⁸ U.C.C. § 9-109(d)(6).

⁵⁹ *Charlotte-Mecklenburg Hospital Authority v. First of Georgia Insurance Company et al.*, 112 N.C. App. 828, 436 S.E.2d 869, *rev'd*, 340 N.C. 88, 455 S.E.2d 655 (1995).

In addition to recognizing the creation of a lien under N.C. Gen. Stat. §§ 44-49, 44-50, the North Carolina Supreme Court distinguished between an assignment of a claim for a personal injury and the assignment of proceeds of such a claim. The Court held that the assignment document at issue rose to the level of an assignment of the proceeds, and not the claim, and that such an assignment did create a lien. A client is prohibited from assigning his or her claim as that would constitute champerty and be against public policy.

Creation & Perfection of a Health Care Provider Lien: With Attorney Representation

First of Georgia seems to suggest that any lien created by an assignment may evaporate once the client hires an attorney. Once an attorney is retained, the lien and disbursement protocol follows N.C. Gen. Stat. §§ 44-49, 44-50. These statutes cover liens claimed by physicians, hospitals, nurses, dentists, ambulance services and seemingly any entity which has provided health care services related to the injury for which your client has recovered. Although chiropractors are not listed, their lien is likely covered.⁶⁰ A healthcare provider lien is “perfected” under N.C.G.S. §§ 44-49, 44-50 when:

1. An attorney requests a client’s medical records or itemized bill from a healthcare provider AND
2. The healthcare provider provides the requested records or itemized bill free of charge AND
3. The healthcare provider sends the attorney written notice of the lien claimed.

Statute of Limitations

The statute of limitations for a healthcare provider to enforce a lien has not been conclusively determined by the legislature or judiciary. It is likely that a suit for violation of a lien could be brought long after the original statute of limitations has run, because the violation may not be deemed to have occurred until the medical provider was not properly paid from a settlement or judgment.⁶¹ Absent a contract stating the date when payment is due, the statute of limitations for a non-lienholder healthcare provider to collect an unpaid balance is 3 years from the date of the last treatment, provided the client has received continuous treatment.⁶² However, a patient may be equitably estopped

from asserting a statute of limitations defense if her attorney represented to the healthcare provider that the bill would be paid out of the settlement proceeds.⁶³

Disbursement Requirements & Procedures

After determining which healthcare providers have liens under N.C.G.S. § 44-49(b), you should determine if there will be enough money remaining after disbursement to make the case worthwhile for your client. After all, it is your client who suffered the painful injuries and underwent the medical treatment and may face future complications. Consider that settlement funds will have to provide for: paying your fee and expenses, repaying in full the lienholders and other unpaid bills your client wants paid, and allowing your client to receive a large enough “share” of the proceeds to make the case worthwhile. If you have enough money to go around, you can do the traditional math. If not, you will need to turn to the help provided by N.C.G.S. §§ 44-49, 44-50. These statutes create a cap on the amount healthcare provider lienholders can extract from your client’s recovery. Under N.C.G.S. §§ 44-49, 44-50, the total liens may not exceed one-half of the remainder of the client’s recovery after deduction for attorney’s fees. In other words, after deducting your attorney’s fees (sorry, the statute does not allow for the “up front” deduction of your expenses), the client is entitled to receive 50% of the remaining funds. This leaves the remaining 50% to be distributed on a pro-rata basis amongst the lienholders. Only perfected liens are entitled to a share.

N.C.G.S. § 44-50.1 creates an affirmative obligation of the attorney to provide “less than paid in full” lienholders with documentation of: (1) the total settlement proceeds, (2) all lien amounts, (3) distribution amounts to respective lienholders, (4) for each lienholder, the percentage of its lien amount that is represented by the distribution amount, and (5) the total amount of attorney’s fees. A pro-rata or other payment to a lienholder that is less than the lien amount does not absolve the client from the obligation to pay the unpaid balance on the lien. Additionally, failure of a healthcare provider to perfect a lien does not absolve the client from the obligation to pay the unpaid charges.

If a lien is perfected and the attorney fails to honor the lien, the lienholder has an enforceable claim against the attorney. This claim is in addition to the claim the health care provider has against the client/patient.⁶⁴ Where the

⁶⁰ See *Triangle Park Chiropractic v. Battaglia*, 139 N.C. App. 201, *review denied*, 352 N.C. 683 (2000).

⁶¹ See NORTH CAROLINA PERSONAL INJURY LIENS MANUAL 11 (2nd ed. 2011).

⁶² *Johnson Neurological Clinic v. Kirkman*, 121 N.C. App. 326, 465 S.E.2d 32 (1996)

⁶³ *Duke University v. Stainback*, 320 N.C. 337, 357 S.E.2d 690 (1987).

⁶⁴ See *Triangle Park Chiropractic v. Battaglia*, *supra*.

lien amount is in dispute, no payment is required “... until the claim is fully established and determined.”⁶⁵

It is recommended that practitioners encourage payment of all medical bills when there are sufficient recovery proceeds. The employment contract should facilitate this approach. However, if the client instructs his attorney not to pay non-lienholder healthcare providers, then the attorney must follow those instructions, even if the original employment contract provides otherwise. As for healthcare providers that hold a perfected lien, if the claim is liquidated (i.e. clear and certain), the lawyer may pay the provider over the client’s objection. If the client disagrees, the attorney may consider filing an interpleader action, paying the disputed funds into the court, and allowing the court to reach a resolution separately. While clearly available, however, the interpleader remedy should be utilized only as a last resort. Try to iron out the dispute between your client and the lienholder so that you, the client, and the lienholder can close the chapter and move on with your respective lives.

SPECIAL NOTE: Entities Not Entitled to Payment Under N.C. Gen. Stat. §§ 44-49 and 44-50

1. *Healthcare providers who have received payments from Medicaid.* Be on the lookout for any of your client’s medical bills that have the language “MEDICAID RECIPIENT; BENEFITS ASSIGNED” or something similar. This language means the healthcare provider has filed a claim with Medicaid for payment of certain treatment or services provided. A healthcare provider who has received payment from Medicaid for a specific service or treatment cannot assert a lien against your client’s recovery for the unpaid balance of the same service or treatment except for certain specific services for which a co-payment may be charged. You need not honor the lien claimed by the healthcare provider and be sure to inform your client that he does not owe the “balance” either. Any balance is essentially waived or erased by the healthcare provider’s acceptance of Medicaid benefits. Balance billing is strictly prohibited as affirmed by a Sixth Circuit opinion in the case of *Spectrum Health v. Anne Marie Bowling*.⁶⁷ Though not binding on a North Carolina Court, the *Spectrum* decision and the fact that no United

States Court has ever allowed a provider to recover on “balance billing” should squash the provider’s claim in your case.

2. *Healthcare providers who have filed with a workers’ compensation carrier or employer.* A health care provider cannot seek recovery from the client for services provided due to a work-related injury “unless the employee’s claim or the treatment is finally adjudicated not to be compensable or the employee fails to request a hearing after denial of liability by the employer.”⁶⁸ A health care provider that seeks to recover payment on a bill incurred by an employee due to treatment for work-related injury could face conviction of a Class 1 misdemeanor.⁶⁹

SPECIAL NOTE: Lien laws of other states

Remember the rules and principles cited in this manuscript only apply to liens for unpaid medical bills of healthcare providers located in North Carolina. If your client has medical treatment or other services provided outside of North Carolina you should look to the laws of the relevant state in order to determine when and how a lien is created. The following information is a thumbnail sketch of some provisions of the lien laws of the respective states. Careful review of the relevant laws is required and a North Carolina attorney may be well-advised to contact an attorney in the relevant state for further information.

VIRGINIA: A healthcare provider can have a valid lien against your client’s recovery but not to exceed the amount of \$2,500.00 in the case of a hospital and \$750 in the case of a physician, nurse, physical therapist, or pharmacy.⁷⁰ In order to create a lien, the healthcare provider must provide the attorney or client with written notice of lien unless the client’s attorney knows medical services were either provided or paid for by the Commonwealth of Virginia.⁷¹ Like N.C. Gen. Stat. § 44-49, the Virginia Code does not specifically require that the notice of lien contain the amount of the lien claimed. Although a good faith argument can be made that a notice of lien is fatally defective if no actual lien amount is stated, you should assess whether it is advisable to just contact the healthcare provider and obtain the amount of their lien.

SOUTH CAROLINA: House Bill 3729 was introduced in 2005 and is still pending. The bill has

65 N.C.G.S. § 44-51.

66 See RPC 69 and RPC 125.

67 *Spectrum Health Continuing Care Group v. Anne Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6th Cir. 2005).

68 N.C.G.S. § 97-90(e).

69 N.C.G.S. § 97-88.3(c).

70 Virginia Code § 8.01-66.2.

71 Virginia Code § 8.01-66.5.

detailed provisions which, among other things, would create a lien against third party recoveries and allow clients to grant an assignment of proceeds of a personal injury claim. Practitioners handling claims in which medical treatment and services were provided in South Carolina should monitor the South Carolina legislature for any new developments.

TENNESSEE: Tennessee Code § 29-22-101 *et seq.* relates to hospital liens. The lien is capped at 1/3 of the damages recovered⁷² and in order to perfect a lien, within 120 days of the patient's release from the hospital, a hospital must file a notice of lien with the clerk of court in the county in which the hospital is located.⁷³ There is no requirement that the hospital send any notice of lien to the attorney or the client.

N.C. WORKERS' COMPENSATION

N.C. Gen. Stat. § 97-10.2(h) establishes a lien in favor of any employer who has provided workers' compensation benefits upon any award in a third party liability case for the reimbursement of monetary and medical benefits conferred upon the employee. As a result, the receipt of any workers' compensation benefits by your client creates a lien against any recovery your client receives from a third-party tortfeasor for the on-the-job injury.⁷⁴ However, negligence by the employer negates the ability to recover for benefits paid by lien.⁷⁵ In addition, uninsured or underinsured motorist monies are subject to a workers' compensation lien.⁷⁶

Jurisdiction over Reduction of a Workers' Compensation Lien

Jurisdiction over the reduction or elimination of a workers' compensation lien is limited to the superior court judge of the county in which the cause of action arose or where the injured employee resides (or presiding judge

of either district).⁷⁷ The superior court judge may reduce or eliminate the workers' compensation lien without the employer's consent even if the result is a double recovery for the plaintiff, so long as a settlement agreement has not been submitted to and approved by the Industrial Commission.⁷⁸ The superior court judge's order binds the Industrial Commission concerning disbursement of the settlement funds. The judge has the power to reduce the employer's lien amount in any manner he believes to be equitable, considering the factual findings of the following five factors: (1) the compensation the employer will likely pay the employee in the future; (2) the net recovery to the plaintiff; (3) the likelihood of the plaintiff prevailing at trial or appeal; (4) the need for finality in the litigation; and (5) any other factors the court deems just and reasonable.⁷⁹

However, before the case can be heard by the superior court, there has to be a "final settlement" between the third party and the employee.⁸⁰ Settlements that are conditioned upon the reduction or elimination of a workers' compensation lien are not considered "final."⁸¹ If all parties agree to have the funds that are subject to a potential lien placed in escrow, the settlement or award may be considered "final."⁸² The superior court may reduce a workers' compensation lien even if the industrial commission has yet to declare a final order, if there has been a final award.⁸³ In addition, the superior court retains jurisdiction to reduce or eliminate a workers' compensation lien even after the third party funds assigned to the lien have been distributed. Also, workers' compensation liens attach to any payments by a third party tortfeasor to any person receiving the funds.⁸⁴

Attorneys' Fees

An employer is required to share in attorney's fees related to the case before the Industrial Commission in direct proportion to his interest in the settlement.⁸⁵ However, N.C. Gen Stat. § 97-10.2(j) does not allow for a deduction of attorney's fees incurred during the

⁷² Tenn. Code Ann. § 29-22-101(b).

⁷³ Tenn. Code Ann. § 29-22-102(a).

⁷⁴ N.C.G.S. § 97-10.2.

⁷⁵ N.C.G.S. § 97-10.2(3).

⁷⁶ See *Creed v. R.G. Swaim & Son*, 123 N.C. App. 124 (1996); *Bailey v. Nationwide*, 112 N.C. App. 47, *aff'd*, 334 N.C. 1, 430 S.E.2d 895 (1993).

⁷⁷ N.C.G.S. § 97-10.2(j).

⁷⁸ *Holden v. Boone*, 153 N.C. App. 254, 569 S.E.2d 711 (2002).

⁷⁹ N.C.G.S. § 97-10.2(j).

⁸⁰ *Ales v. T. A. Loving Co.*, 163 N.C. App. 350, 353 (2004) (interpreting [N.C. Gen. Stat. § 97-10.2\(j\)](#) as permitting the superior court to adjust the amount of a subrogation lien if the agreement between the parties has been finalized so that only performance of the agreement is necessary to bind the parties.)

⁸¹ *Id.*

⁸² *Wood v. Weldon*, 160 N.C. App. 697 (2003).

⁸³ *Childress v. Flour Daniel, Inc.*, 172 N.C. App. 166 (2005).

⁸⁴ *In Re Estate of Bullock v. C.C. Mangum Co.*, 188 N.C. App. 518, 525 (2008).

⁸⁵ N.C. Gen Stat. § 97-10.2(f)(2).

lien reduction hearing before the superior court.⁸⁶ An employer is only required to pay its fair share of costs and expenses incurred by the plaintiff in obtaining the judgment.⁸⁷ An employer's insurance carrier steps into the shoes of the employer and is given the same rights and obligations.⁸⁸

Special Note: Uninsured & Underinsured Motorist Coverage

N.C. Gen Stat. § 20-279.21(e) requires all UM/UIM policies to insure against the plaintiff's damages that are uncompensated by any worker's compensation payments and the amount of a workers' compensation lien. The effect of this statute is that a UM/UIM policy is required to compensate the plaintiff, up to its policy coverage limit, if a reduction or elimination of a workers' compensation lien is granted by the superior court. Courts have interpreted this statute quite favorably to plaintiffs, and the opportunity should be exploited by a plaintiff's attorney.⁸⁹

Procedures for Handling Workers' Compensation Liens

If a "final settlement" has been reached with the third party and attempts to settle the lien have been unsuccessful, a suit may be commenced in superior court for the purpose of reducing or eliminating the lien in two ways. First, an attorney may file a written complaint against the third party tortfeasor. This has the advantage of not requiring the employer or insurance carrier to be initially named as defendants, but the carrier's claims adjuster and attorney should still be notified of the suit.⁹⁰ Second, an attorney may file a petition without a complaint against the employer and third party liability insurance carrier. This will require more procedural work than the previous option, but is still sufficient to invoke jurisdiction for the suit.

State law restricts the period in which an employee has the exclusive ability to enforce his rights against a third party tortfeasor in a workers' compensation case. The employee has the exclusive right to seek enforcement against the third party tortfeasor during the first 12 months following the injury.⁹¹ If an employee does not act on

his rights during that time, the employee and employer will share a joint right to sue until the exclusivity period is reactivated (if neither party has filed a suit) during the 60 days immediately preceding the expiration of the statute of limitations applicable to the claim against the third party.⁹²

It is also very important for the attorney to note that N.C.G.S. § 97-10.2(f)(1) requires the attorney to get final approval of the distribution from the Industrial Commission before distributing. An attorney must also distribute in the following priority: (1) to the employee for court costs and expenses incurred in litigation; (2) to the attorneys for fees; (3) to the employer for his award; and (4) to the employee for his award.

STEP 1 — You should request that the employer or its carrier/third party administrator provide you with a fully itemized listing of all benefits paid that compose their claimed lien amount. Review and scrutinize the lien listing to eliminate any unrecoverable items.

STEP 2 — After determining the amount of recoverable charges that will compose the lien, contact the carrier regarding a reduction of the lien amount. You should seek to negotiate a reduction of repayment on virtually all workers' compensation liens. [NOTE: If you seek to reduce the lien repayment amount, you must do this before you have your client sign a compromise settlement agreement that is approved by the Industrial Commission. Once the Commission approves the settlement agreement, it is too late.⁹³]

If the carrier is unwilling to negotiate favorably yet has some unclean hands due to the handling of the workers' compensation case, it is time to use the pen (or computer) as your sword. Send the carrier a letter requesting a reduction of the lien amount and also take care to list any and all "bad faith" acts by the employer or carrier over the course of the case. Examples of such are unjustified delays in the payment of weekly indemnity benefits, unreasonable delay in authorizing medical treatment or procedures prescribed by your client's primary treating physician, and

86 *Alston v. Fed. Express Corp.*, 200 N.C. App. 420 (2009).

87 *Id.*

88 N.C.G.S. § 97-10.2(g).

89 *Austin v. Midgette*, 159 N.C. App. 416 (2003)(Austin I); *Austin v. Midgette*, 166 N.C. App. 740 (2004)(Austin II); *Walker v. Penn National Security Insurance Company*, 168 N.C. App. 555 (2005).

90 N.C.G.S. 97-10.2(d).

91 N.C.G.S. § 97-10.2(b).

92 N.C.G.S. § 97-10.2(c).

93 *Holden v. Boone*, 153 N.C. App. 254 (2002).

the provision of unsuitable employment.

STEP 3a — If you reach a written agreement with the carrier regarding a lien reduction, your work is not quite done. Any disbursement to the client must be preceded by an application and an order from the North Carolina Industrial Commission approving such disbursement. Have the comp carrier join in and sign your application. It may also be helpful to have you sign either the application or a Settlement Statement that evidences the agreed upon lien reduction amount as well as the employer/carrier's intention not to appeal. You will need to receive the signed order from the Industrial Commission before you disburse any recovered funds.

STEP 3b — If you are unable to reach an agreement with the workers' compensation carrier regarding a reduced lien repayment amount, do not despair. N.C.G.S. § 97-10.2(j) allows the employee to petition a Resident or Presiding Superior Court Judge to reduce or eliminate the subrogation amount to be paid to the employer or insurance carrier after proper notice to the employer. The statute states that the judge has the right to determine the amount of reimbursement in his/her "discretion." If the third party case is pending in Federal Court, your petition must be made therein. The Industrial Commission cannot order the carrier to accept less than the statutory lien amount. Only a judge has this authority. After a judicial decision on your petition, you must still prepare an application and proposed order to the Industrial Commission approving disbursement. It would still be helpful to have a letter showing the carrier/employer's lack of intent to appeal the decision. In the event of an appeal, the total amount of the lien should be kept in the trust account until all appeals are exhausted.

U.S. WORKERS' COMPENSATION

The Federal Employees' Compensation Act (FECA) governs a federal employee's rights and duties concerning the receipt of workers' compensation benefits. If an employee suffers an on-the-job injury involving a liable third party, FECA requires the employee to either pursue recovery against the third party personally or assign their claim to the Federal Government in order to receive workers' compensation benefits.⁹⁴ A client that does not wish to sue the third party may request a release pursuant to 20 C.F.R. § 10.709. The Department of Labor will decide whether to grant a release from the obligation at its discretion. Such a release has no effect on the government's right to be reimbursed. The attorney and client both have an obligation to take action against a third party (including filing a suit) and to keep the government updated. If either party does not comply, the client's benefits may be suspended or revoked.⁹⁵ Unlike employers in state workers' compensation claims, the Federal Government lacks the authority to pursue an independent action against the tortfeasor without assignment from the beneficiary.

5 U.S.C. § 8132 of FECA gives the government a "statutory right to reimbursement," which is tantamount to a lien on the settlement funds related to the injury for which the employee received benefits. The federal government claims a lien upon proceeds and the source of funds in first party claims. The government cannot waive or compromise any part of its reimbursement right, however the statute allows the client to retain at least 1/5 of the net recovery remaining after the deduction of expenses.⁹⁶ The lien attaches to all of the funds, even if they are apportioned for injury not directly related to the medical and wage benefits conferred by workers' compensation (e.g. pain and suffering).⁹⁷ The portion of a settlement awarded to a spouse for their related injuries may not even be protected, as the Department of Labor has the authority to determine the appropriate allocation.⁹⁸ The statute allows for the reduction of the federal government's recovery by the proportionate amount of a reasonable attorney's fee.⁹⁹ The court is given the discretion to determine whether a fee is "reasonable"¹⁰⁰

⁹⁴ 5 U.S.C. § 8131(b).

⁹⁵ 20 C.F.R. § 10.708.

⁹⁶ 5 U.S.C. § 8132.

⁹⁷ *U.S. v. Lorenzetti*, 467 U.S. 167 (1984).

⁹⁸ *Gonzalez v. Department of Labor*, 609 F.3d 451 (D.C. Cir. 2010) *rehearing en banc denied*

⁹⁹ 5 U.S.C. § 8132.

¹⁰⁰ *Sandoval v. Mitsui Sempaku K.K. Tokyo*, 460 F.2d 1163 (5th Cir. 1972).

and can reduce the government's share of the fees as it sees fit.¹⁰¹ If a client pays the attorney a flat fee for representation, the court may limit the government's share of attorney's fees to the amount paid by the client.¹⁰² Fees earned on a contingency fee basis have been declared "reasonable" by the court when set at thirty percent.¹⁰³ An attorney should probably use a pure contingency or flat fee approach to these types of cases, given the court's unfavorable reactions to hybrid fees.

A beneficiary may not settle a claim for less than the government's entitlement to reimbursement without written permission from the government.¹⁰⁴ In addition, an attorney is required to either satisfy or assure satisfaction of the government's lien before distributing funds to the beneficiary.¹⁰⁵ Failure to adequately reimburse the government will result in the attorney's personal liability for the funds.¹⁰⁶ Considering the tight statutory control provided by FECA and the attorney's statutory duties to the government, any attorney involved in a federal workers' compensation situation involving would be well advised to inform the appropriate authorities and cooperate with those authorities as if they were his own clients.

TRICARE (FORMERLY KNOWN AS CHAMPUS)

The Federal Medical Recovery Act (42 U.S.C. §§ 2651-2653) allows the federal government to be reimbursed for its costs of treating a TRICARE beneficiary. TRICARE's recovery measures and methods are stated in 10 U.S.C. § 1095, *et seq.* TRICARE is a program of medical assistance for veterans (often referred to as "sponsors" in government correspondence), their spouses and their children.

The government has a lien on the proceeds of recovery for any sums paid for or incurred by the services rendered by Veterans' Administration hospitals or private health care providers. This lien attaches to the source of funding, as well as the proceeds of settlement. This lien is not limited or controlled by state law which means the government can (and sometimes does) pursue a claim of its own directly against the tortfeasor and his insurance company. Once a qualified beneficiary reaches Medicare age, TRICARE benefits become secondary coverage. If the qualified beneficiary has other coverage available, it

will become secondary above TRICARE.

Once you determine that your client has received TRICARE benefits you need to ascertain the name, social security number, and branch of service of the veteran who is the conduit through which your client is entitled to receive TRICARE benefits. If your client is a veteran, this information will be one and the same. Next, you will need to forward the above-described contact information along with the date and place of incident to the nearest military base of the branch of service to which the veteran belongs(ed). Your letter should be directed to the Affirmative Claims Recoveries Branch of the Federal Medical Case Recovery Section in the Office of the Staff Judge Advocate for that service. You or the client may be required to complete a DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability" to assist the government in preparing its itemized lien statement.

Each branch of service has its own jurisdictional boundaries. Jurisdiction is usually assigned to the base closest to the site of the incident giving rise to the injury. However, if the injury occurs in one jurisdiction with minimal treatment in that jurisdiction, and follow-up treatment is extensive in another jurisdiction, the treating jurisdiction will probably handle the case. Further, each branch has a unique procedure regarding handling and recovery of liens.

The TRICARE lien is subject to adjustment and can be reduced or waived by the Claims Recovery Office when justice requires. There is no deduction permitted for attorney's fees, and there is no cap on the amount of the lien. By law, a Claims Recovery Officer has limited initial authority to compromise or waive the lien. Whether a TRICARE lien will be compromised will ultimately depend on how much the beneficiary will receive. For instance, if the proposed compromise would reap few benefits to the beneficiary but more to the attorney, chances of compromise will be slim. On the other hand, if there is a recovery for less than the full value of the claim and other lienholders or claimants (including attorneys) are willing to adjust their claims, chances of a compromise with the Claims Recovery Office improve. The plaintiff's attorney should keep in close contact with the Recovery Office and plead the case for compromise armed with sufficient facts and arguments to justify an adjustment.

101 *Gonzalez v. Dept. of Labor*, 603 F.Supp.2d 137, aff'd 609 F.3d 451, (D.C. Cir. 2010) *rehearing en banc denied*

102 *Purser v. U.S. Dept. of Labor*, 943 F.Supp. 898 (M.D. Tenn. 1996).

103 *Price v. Pretto*, 335 F.Supp. 1325 (D.C.Z. 1972).

104 20 C.F.R. § 10.707.

105 5 U.S.C. § 8132.

106 *See Gonzalez v. Department of Labor, supra.*

The limit on the dollar amount of the local Claims Recovery Officer's authority to compromise a claim are subject to adjustment. Further, each service has its own methodology which it follows, and some services require more supporting documents than others, especially when compromising a large claim. *KEYNOTE*: Federal law prohibits payment of an attorney fee for assertion or collection of a claim by the government.¹⁰⁷

VOCATIONAL REHABILITATION

This lien is created by N.C. Gen. Stat. § 143-547. Vocational Rehabilitation claims a lien against any source, including payments made under the claimant's own medical payments coverage, uninsured motorist coverage, underinsured motorist coverage, personal insurance, workers' compensation, or any other source. A Vocational Rehabilitation lien only applies in those cases where a financial needs test was administered in order to receive benefits. If no financial needs test was required, then no lien attaches.¹⁰⁸ Vocational Rehabilitation takes the position that it has a statutory right of subrogation and can make a claim and sue the tortfeasor directly. Accordingly, an attorney should review all medical, hospital, and rehabilitation facility records as well as billing and charge statements to determine if Vocational Rehabilitation is involved.

The formula for payment of a Vocational Rehabilitation lien is set forth in N.C. Gen. Stat. § 143-547(a). The statutory formula allows deductions for attorney's fees and costs but not to exceed one-third of the amount recovered. The amount of the lien is likewise capped at one-third of the amount recovered. Additionally, if there are other liens to be paid out of the recovery, the statute allows you to pro-rate the Vocational Rehabilitation lien with such liens.

Should there be insufficient funds available to repay the lien, N.C. Gen. Stat. § 143-547 permits the Division of Vocational Rehabilitation Services to totally or partially waive subrogation rights. This may be done when the Division finds that enforcement would tend to defeat the client's process of rehabilitation, or when the client's assets can be used to offset additional Division costs.

AMBULANCE SERVICE LIENS

N.C. Gen. Stat. § 44-51.1 *et seq.* contains the provisions relating to ambulance service liens. N.C. Gen. Stat. § 44-51.8 contains a long list of the counties to which the ambulance service lien applies. Although the list seems to include virtually every county, you should still consult the statute to see if the county relevant to your case is covered. There is no statutory allowance for an attorney's fee or costs reduction of ambulance service liens.

Ambulance service liens must be filed with the Clerk of Superior Court in order to be perfected. Ambulance service liens can be asserted versus real property only if the lien was filed with the Clerk of Superior Court within 90 days after the date service was furnished.¹⁰⁹ The county can utilize garnishment or attachment proceedings to recover the lien amount from your client if the lien was filed with the Clerk of Superior Court within 91 to 180 days after the date service was furnished.¹¹⁰ This means that your client's wages, bank deposits, personal property, etc., are potential recovery sources for the county. A county's failure to file their outstanding bill with the Clerk of Superior Court within the requisite time period means only that the county cannot undertake the aforementioned procedures to recoup its money. The county would retain a lien under N.C. Gen. Stat. §§ 44-49 and 44-50. The lien exists for 10 years from the date the service was furnished or 3 years from the date of the recipient's death.¹¹¹

¹⁰⁷ 5 U.S.C. § 3106.

¹⁰⁸ N.C.G.S. § 143-547(c).

¹⁰⁹ N.C.G.S. § 44-51.2.

¹¹⁰ N.C.G.S. § 44-51.6.

¹¹¹ N.C.G.S. § 44-51.1.

SAMPLE REQUEST FOR PLAN DOCUMENTS

Date

(Name of Plan Administrator – should be set forth in SPD)

Plan Administrator for _____ Medical Plan

Street Address

City, State, Zip Code

CERTIFIED MAIL: Return Receipt Requested

Dear Mr./Ms.:

My name is _____. Pursuant to my right as a participant and beneficiary of _____ Plan, I respectfully request copies of the following materials:

Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years, _____, _____, _____, and _____. (year preceding date of injury through current year); and

Administrative Services Contract between _____ (Employer/Plan) and _____ (Plan Insurer(s)/Claim Administrator) for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of all contracts including, but not limited to: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts related to _____ Medical Plan serving (insert name of state or region encompassing client) participants for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Amendments to the Plan Documents for _____ Medical Plan (including, but not limited to the Summary Plan Description) for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of the SMM (Summary of Material Modifications) statements for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years _____, _____, _____, and _____. (year preceding date of injury through current year).

Please forward these materials to my attorney, Mr./Ms. _____, (street address), (city), (state), (zip code).

Thank you.

(signature)
(Name of Participant/Beneficiary – PRINTED)
Plan Participant
Plan Beneficiary

SAMPLE FORM 5500: ANNUAL RETURN/REPORT OF EMPLOYEE BENEFIT PLAN

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p align="center">Annual Return/Report of Employee Benefit Plan</p> <p align="center">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).</p> <p align="center">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p align="right">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p align="center">2012</p> <hr/> <p align="center">This Form is Open to Public Inspection</p>
---	--	---

Part I	Annual Report Identification Information
For calendar plan year 2012 or fiscal plan year beginning _____ and ending _____	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.....▶	<input type="checkbox"/>
D Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information						
1a Name of plan	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">1b Three-digit plan number (PN) ▶</td> <td></td> </tr> <tr> <td>1c Effective date of plan</td> <td></td> </tr> </table>	1b Three-digit plan number (PN) ▶		1c Effective date of plan			
1b Three-digit plan number (PN) ▶							
1c Effective date of plan							
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">2b Employer Identification Number (EIN)</td> <td></td> </tr> <tr> <td>2c Sponsor's telephone number</td> <td></td> </tr> <tr> <td>2d Business code (see instructions)</td> <td></td> </tr> </table>	2b Employer Identification Number (EIN)		2c Sponsor's telephone number		2d Business code (see instructions)	
2b Employer Identification Number (EIN)							
2c Sponsor's telephone number							
2d Business code (see instructions)							

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		Date	Enter name of individual signing as plan administrator
	Signature of plan administrator		
SIGN HERE		Date	Enter name of individual signing as employer or plan sponsor
	Signature of employer/plan sponsor		
SIGN HERE		Date	Enter name of individual signing as DFE
	Signature of DFE		
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)			Preparer's telephone number (optional)

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2012)
v. 120126

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).	
a Active participants	6a
b Retired or separated participants receiving benefits	6b
c Other retired or separated participants entitled to future benefits.....	6c
d Subtotal. Add lines 6a , 6b , and 6c	6d
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e
f Total. Add lines 6d and 6e	6f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

RPC 69

October 20, 1989

PAYMENT OF CLIENT FUNDS TO MEDICAL PROVIDERS

Opinion rules that a lawyer must obey the client's instruction not to pay medical providers from the proceeds of settlement in the absence of a valid physician's lien.

Inquiry:

Attorney A represents Client C in a personal injury action. Client C directs Attorney A to seek the cooperation of various medical providers and to inform them that their fees will be paid from the proceeds of any settlement.

Attorney A writes the medical care providers and requests the medical records of Client C. He also requests a statement of charges from the medical providers. Subsequently, the medical providers send copies of Client C's account to Attorney A.

After settlement of the personal injury claim, Client C instructs Attorney A not to pay the medical providers, but to pay those sums directly to her. Client C claims she has a dispute with the medical providers as to the amount owed.

May Attorney A ethically refuse to pay the subject funds directly to Client C?

Would there be a different response to this question if Client C had never directed Attorney A to inform the medical providers that their fees would be paid following Client C's recovery in the personal injury action?

Opinion:

Rule 10.2(E) of the North Carolina Rules of Professional Conduct provides that, "[A] lawyer shall promptly pay or deliver to the client or to third persons as directed by the client the funds, securities, or properties belonging to the client to which the client is entitled in the possession of the lawyer." A lawyer is generally obliged by this rule to disburse settlement proceeds in accordance with his client's instructions. The only exception to this rule arises when the medical provider has managed to perfect a valid physician's lien. In such a situation the lawyer is relieved of any obligation to pay the subject funds to his or her client, and may pay the physician directly if the claim is liquidated, or retain in his or her trust account any amounts in dispute pending resolution of the controversy.

In those cases where the client has authorized the lawyer to represent to the medical provider that the provider's fees will be paid from the proceeds of settlement and thereafter forbids the lawyer to pay the physician, the lawyer is, as the client's agent and trustee of the client's funds, under an obligation to comply with the client's instructions. If the lawyer is of the opinion that he might thereby be facilitating his client's fraud, it would not be inappropriate for the lawyer to advise the medical provider of the client's change of heart in sufficient time for the medical provider to pursue any remedies it might have in anticipation of the disbursement of the settlement proceeds. *See* Rule 4(c)(4). Should no action be taken by the medical provider within a short specified time, the lawyer would then be obligated to comply with his or her client's instructions. *See also N.C. Baptist Hospitals v. Mitchell*, 323 N.C. 528 (1989).

RPC 75

October 20, 1989

DISBURSEMENT OF CLIENT FUNDS

Opinion rules that a lawyer may not pay his or her fee or the fee of a physician from funds held in trust for a client without the client's authority.

Inquiry:

Last year Lawyer L began representation of Ms. B for injuries she received in an automobile accident. Since that time Ms. B has failed to cooperate in the processing of her claim, has not given any response to numerous letters, has not returned telephone messages, and has not accepted a certified letter. Lawyer L feels that he is no longer in a position to provide representation to Ms. B based on her lack of cooperation.

The question which has arisen deals with a \$353.00 balance which is maintained in the trust account on behalf of Ms. B. This represents a portion of the medical payments coverage which was received on behalf of Ms. B. Lawyer L generally obtains medical payments coverage for his clients as a courtesy with no deduction of legal fees. However, Lawyer L has spent a great deal of time on this case and feels that he should be entitled to some fee. Additionally, Ms. B has signed a doctor's lien in favor of Dr. K.

Lawyer L has on several occasions written Ms. B asking her to authorize him to disburse this amount to Dr. K for his outstanding expenses and to himself in payment for legal services performed. There has been no response. May Lawyer L ethically take a reasonable legal fee from this balance and forward the remainder to Ms. B's physician for his services?

Opinion:

No. Rule 10.2(E) of the Rules of Professional Conduct [Rule 1.15-2 of the Revised Rules] requires a lawyer holding client funds in trust to pay or deliver those funds only as directed by the client. In this case the client has evidently not offered any direction regarding the disbursement of the funds in question and Lawyer L should therefore continue to hold this money in trust. Although there would appear to be a valid physician's lien against some portion of the trust funds, Lawyer L should refrain from disbursing any money to Doctor K until he obtains his client's consent to pay some or all of the amount billed or is required to pay some liquidated amount by a valid court order. Any funds which are the subject of an ongoing dispute should be retained in trust.

RPC 125

January 17, 1992

DISBURSEMENT OF SETTLEMENT PROCEEDS

Opinion rules that a lawyer may not pay a medical care provider from the proceeds of a settlement negotiated prior to the filing of suit over his client's objection unless the funds are subject to a valid lien.

Inquiry:

Lawyer A represents a plaintiff in a personal injury action. During the course of settling the case, the attorney receives medical bills from medical care providers which treated the client for the personal injuries. Settlement is reached without the filing of a lawsuit. There is no dispute over the medical bills. The client instructs Lawyer A to pay all proceeds of the settlement over to her and to not pay the medical bills. The medical care providers have not taken the steps set forth in G.S. §44-49 to perfect the lien provided in that statute, but Lawyer A has actual notice of the bills (see G.S. §44-50). Does RPC 69 mandate that the attorney pay the settlement proceeds to the client rather than following the distribution scheme set forth in G.S. §44-50?

Opinion:

RPC 69 ruled that an attorney has an ethical obligation to disburse funds belonging to the client as instructed by the client in the absence of a valid lien in favor of a health care provider. Rule 10.2(e) [Rule 1.15-2 of the Revised Rules]. From the standpoint of the Rules of Professional Conduct, the situation is the same regardless of whether the case is settled before or after the initiation of litigation. The interpretation of G.S. §44-50 is beyond the purview of the ethics committee. Suffice it to say that if that statute has the effect of imposing a lien upon settlement proceeds in the hands of an attorney when the attorney has received actual notice of the medical care provider's claim and suit has not been filed, then the attorney may pay the medical care provider's undisputed claim in spite of his client's objection. If, on the other hand, a lien is not perfected by the attorney's acquisition of actual notice under such circumstances, the attorney would have to abide by the instructions of the client in regard to the disbursement of the proceeds of settlement.

RPC 228

July 26, 1996

Editor's Note: This opinion was originally published as RPC 228 (Revised).

INDEMNIFYING THE TORTFEASOR'S LIABILITY INSURANCE CARRIER FOR UNPAID LIENS OF MEDICAL PROVIDERS AS A CONDITION OF SETTLEMENT

Opinion rules that a lawyer for a personal injury victim may not execute an agreement to indemnify the tortfeasor's liability insurance carrier against the unpaid liens of medical providers.

Inquiry:

Attorney A represents Client A who was injured in an automobile collision caused by the negligence of Mr. X. Mr. X has liability insurance with Insurance Carrier. Attorney A negotiated a settlement of Client A's claim with Insurance Carrier for a sum certain. However, Insurance Carrier's settlement offer is conditioned upon the execution by Attorney A and Client A of an indemnity agreement in addition to the traditional general release. In the indemnity agreement, Attorney A would agree to indemnify Insurance Carrier against all claims Insurance Carrier might sustain as a result of any outstanding medical lien incurred by Client A as a result of the accident. The agreement requires Insurance Carrier to notify Attorney A of all medical provider claims or liens of which Insurance Carrier has actual or constructive knowledge. Is it ethical for Attorney A to sign the indemnity agreement as a part of the settlement of Client A's claim?

Opinion:

No. Rule 5.1(b) of the Rules of Professional Conduct . [Rule 1.7 of the Revised Rules]

RPC 231

October 18, 1996

Editor's Note: This opinion was originally adopted as RPC 231 (Revised).

COLLECTING A CONTINGENT FEE ON THE GROSS RECOVERY AND ON THE MEDICAL INSURANCE PROVIDER'S CLAIM

Opinion rules that a lawyer may not collect a contingent fee on the reimbursement paid to the client's medical insurance provider in addition to a contingent fee on the gross recovery if the total fee received by the lawyer is clearly excessive.

Inquiry #1:

Attorney A's contingent fee agreement with Client for representation in a personal injury case will pay Attorney A a fee of one-third of the gross recovery from the defendant plus whatever contingent legal fee may be provided by law for recovering and paying the claim for reimbursement of an insurance carrier or medical insurance program that paid some or all of the client's medical expenses. Is it ethical for a lawyer to collect a contingent fee on the gross recovery and an additional contingent fee for recovering and paying the claim of the medical insurance carrier or program?

Opinion #1:

No opinion is expressed as to whether a legal fee for collecting a medical insurance provider's claim for reimbursement is permitted by law. If such a fee is permitted by law, the collection of this fee in addition to the collection of a contingent fee on the gross recovery may render the lawyer's total fee for the representation of the client "clearly excessive" in violation of Rule 2.6(a) of the Rules of Professional Conduct [Rule 1.5 of the Revised Rules]. Whether the total fee is "clearly excessive" depends upon the facts and circumstances of the particular representation. "Contingent fees, like all legal fees, must be reasonable." RPC 35. Further, a lawyer may not charge a clearly excessive fee even though the fee may be recovered from an opposing party. RPC 196

Rule 2.6(b) [Rule 1.5 of the Revised Rules] provides that "[a] fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence experienced in the area of law involved would be left with a definite and firm conviction that the fee is in excess of a reasonable fee." The rule then lists a number of factors to be taken into consideration in determining the reasonableness of a fee including the following:

- (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
- ...
- (4) the amount involved and the results obtained;
- (5) the time limitations imposed by the client or by the circumstances;
- ...
- (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
- (8) whether the fee is fixed or contingent.

A lawyer may not know at the beginning of the representation whether collecting the additional fee will render the lawyer's total fee clearly excessive in violation of the rule. However, at the conclusion of the representation, the lawyer should examine the factors listed in Rule 2.6(b) to determine the reasonableness of the total fee. If the collection of the additional fee renders the total fee paid to the lawyer clearly excessive in light of these factors, the lawyer should reduce the fee paid by the client in an amount equivalent to the fee permitted by law for collecting and paying the claim of the medical insurance provider.

Inquiry #2:

At the beginning of the representation, should the lawyer disclose to the client the lawyer's intention to seek the fee from the medical insurance provider in addition to the contingent fee payable by the client on the gross amount of the recovery?

Opinion #2:

Yes, the fee arrangement should be fully explained to the client and the client should agree to the fee arrangement. See Rule 2.6 [Rule 1.5 of the Revised Rules] and comment.