

**STATUTORY LIENS:
HOW TO TELL WHEN THE MONEY BELONGS TO SOMEONE ELSE,
AND WHAT TO DO WHEN IT DOES**

By

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I. INTRODUCTION

II. FEDERAL STATUTORY LIENS

A. Federal Medical Care Recovery Act – 42 U.S.C. §§ 2651-2653

In 1962, Congress passed the Federal Medical Care Recovery Act (FMCRA), 42 U.S.C. §§ 2651-2653. The FMCRA provides that when the United States is authorized or required to provide medical care or treatment to a person who is injured or suffers a disease under circumstances creating tort liability upon a third person, the United States has the right to recover from the tortfeasor the reasonable value of such care and treatment.¹ Moreover, the United States has the right to recovery any wages paid by the federal government to a member of uniformed services unable to perform duties as a result of the injury or disease.²

Recovery pursuant to the FMCRA is limited to “circumstances creating a *tort liability* upon some third person.”³ The FMCRA relies upon the law of the state whether the injury takes place to determine whether “tort liability” exists.⁴ Therefore, the FMCRA does not apply to contractual theories or no-fault systems of recovery, such as workers’ compensation laws.⁵

Because the FMCRA focuses on recovery from tortfeasors, the government’s right of recovery will typically not arise in a workers’ compensation claim.

¹ 42 U.S.C. § 2651(a) (2006).

² 42 U.S.C. § 2651(b).

³ 42 U.S.C. § 2651(a) (emphasis added).

⁴ *United Servs. Auto. Ass’n v. Perry*, 102 F.3d 144, 150 (5th Cir. 1996).

⁵ *Pennsylvania Nat’l Mut. Casualty Ins. Co. v. Barnett*, 445 F.2d 573, 576 (5th Cir. 1971); *United States v. Gusto Distrib. Co.*, 329 F. Supp. 578, 579 (D. Mont. 1971).

B. TRICARE – 10 U.S.C. §§ 1095, 1095b

The federal government has a right of recovery embodied in 10 U.S.C. § 1071 *et seq.*, the Act that authorizes the TRICARE program (formerly known as CHAMPUS).⁶ The TRICARE program is the managed health program established by the Department of Defense that provides health care services to active duty members, dependents of active duty members, retired members, dependents of retired members, and survivors.⁷ The United States has a right to recover from third-parties the reasonable cost of medical care furnished to or paid on behalf of TRICARE beneficiaries.⁸

Pursuant to 10 U.S.C. § 1095, which was originally enacted in 1986, the United States can collect the reasonable cost of care provided by a facility of the uniformed services. Specifically, section 1095 provides:

In the case of a person who is a covered beneficiary, the United States shall have the right to collect from a third-party payer reasonable charges for health care services incurred by the United States on behalf of such person through a facility of the uniformed services to the extent that the person would be eligible to receive reimbursement or indemnification from the third-party payer if the person were to incur such charges on the person's own behalf.⁹

For example, under section 1095, if an active duty service member is injured in an automobile accident caused by another person and receives free medical treatment at an Army hospital, the government can recoup the reasonable cost of the medical treatment from the negligent party or its insurance company.

Moreover, in 1989, Congress created 10 U.S.C. § 1095b in 1989 and thereby further extended the right of recovery to include costs of medical care furnished to or paid on behalf of all TRICARE beneficiaries.¹⁰ Section 1095b, which allows the Secretary of Defense to authorize certain TRICARE claims to be paid before seeking recovery from a third-party payer, establishes the obligation of a third-party payer to reimburse the United States the TRICARE costs incurred on behalf of TRICARE beneficiaries.¹¹ For example, under section 1095b, if a retiree suffers a compensable occupational disease and receives medical care at a private hospital paid for by TRICARE, the government can recover the reasonable charge of the medical treatment from the employer or workers' compensation carrier.

⁶ The TRICARE program offers eligible beneficiaries three options for receiving health care: TRICARE Prime, which is an HMO-like program; TRICARE Extra, which is a PPO program; and TRICARE Standard, which is the former CHAMPUS program. 32 CFR § 199.17 (2006).

⁷ 10 U.S.C. § 1072(5), (7) (2006); 32 CFR §§ 199.3, 199.17 (2006).

⁸ 10 U.S.C. §§ 1095, 1095b (2006); 32 CFR §§ 199.12 (2006).

⁹ 10 U.S.C. § 1095.

¹⁰ 10 U.S.C. § 1095b.

¹¹ 10 U.S.C. § 1095b; 32 CFR § 199.12.

The term “third-party payer” includes any entity that provides an insurance, medical service, or health plan by contract or agreement, including liability insurance carriers and no-fault insurance carriers.¹²

Federal regulations establish the “reasonable” cost of health care services based on diagnosis-related groups.¹³ The lien amount does not include any deductible or co-payment paid by the covered beneficiary.¹⁴

The United States may institute and prosecute legal proceedings against a third-party payer to enforce its rights under sections 1095 and 1095b.¹⁵ The United States may also agree to compromise, settle, or waive claims against third-party payers.¹⁶

If a workers’ compensation claim involves a plaintiff who was treated at a uniformed services hospital or received medical care paid for by TRICARE, it is necessary to contact Affirmative Claims in the Claims Division of the Office of the Staff Judge Advocate for the plaintiff’s branch of service.

C. Veterans’ Benefits – 38 U.S.C. § 1729

Congress also passed additional medical recovery legislation for the Department of Veterans Affairs. The Veterans’ Benefits Statute, 38 U.S.C. § 1701 *et seq.*, gives the United States the right to recover from a third party the reasonable value of medical care or treatment provided to a veteran for a non-service-connected disability.¹⁷

Specifically, 38 U.S.C. § 1729 provides:

[I]n any case in which a veteran is furnished care or services . . . for a non-service-connected disability . . . the United States has the right to recover or collect reasonable charges for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.¹⁸

For example, under section 1729, if a veteran with a service-connected disability to his knees suffers a compensable on-the-job injury to his back and receives free medical treatment at a VA Medical Center, the government can recoup the reasonable cost of the medical treatment from the employer or workers’ compensation carrier.

¹² 10 U.S.C. §§ 1095(h), 1095b(c).

¹³ 10 U.S.C. § 1095(f); 32 CFR § 199.14, 220.8.

¹⁴ 10 U.S.C. § 1095(a)(1).

¹⁵ 10 U.S.C. §§ 1095(e)(1), 1095b(b).

¹⁶ 10 U.S.C. §§ 1095(e)(1).

¹⁷ 38 U.S.C. § 1729 (2006).

¹⁸ 38 U.S.C. § 1729(a)(1).

The United States' right of recovery applies to the non-service-connected disabilities described in the Veterans' Benefits Statute, including a disability "that is incurred incident to the veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability."¹⁹

The term "third party" is defined by statute to specifically include "an employer or an employer's insurance carrier."²⁰ Reimbursement and indemnification are included within the term "payment."²¹ Federal regulations establish the "reasonable charges" for care or services.²²

To enforce its right of subrogation, "the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party."²³ The United States can also institute and prosecute a claim for recovery if the veteran did not bring an action within 180 days after the first date of care or services, the United States sent written notice to the veteran of its intent to pursue a claim, and a period of 60 days has passed following the mailing of such notice.²⁴ However, the United States has a six (6) year statute of limitations for bringing such a claim.²⁵

The United States may also agree to compromise, settle, or waive claims against the third party.²⁶

If the plaintiff in a workers' compensation claim is a veteran who was treated at a VA Medical Center, it is necessary to contact the Office of Regional Counsel of the Department of Veterans Affairs. The addresses and telephone numbers for the Office of Regional Counsel in North Carolina are:

Office of Regional Counsel
VA Medical Center, Room NG040
508 Fulton Street
Durham, NC 27705
Phone: (919) 416-5914

Office of Regional Counsel
Hiram H. Ward Federal Building
251 North Main Street
Winston Salem, NC 27101
Phone: (336) 631-5014

¹⁹ 38 U.S.C. § 1729(a)(2)(A).

²⁰ 38 U.S.C. § 1729(i)(3)(B).

²¹ 38 U.S.C. § 1729(i)(2).

²² 38 U.S.C. § 1729(c)(2).

²³ 38 U.S.C. § 1729(b).

²⁴ 38 U.S.C. § 1729(b)(2)(B).

²⁵ 38 U.S.C. § 1729(b)(2)(C).

²⁶ 38 U.S.C. § 1729(c)(1).

D. CHAMPVA—38 U.S.C. § 1781

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), which is administered by the Department of Veterans Affairs Health Administration Center (HAC), provides medical care for survivors and dependants of certain veterans under 38 U.S.C. § 1781. To be eligible for CHAMPVA, the beneficiary cannot be eligible for TRICARE.²⁷ CHAMPVA beneficiaries include the spouse or child of (1) a veteran who is permanently and totally disabled as a result of a service-connected disability; (2) a veteran who (a) died as a result of a service-connected disability, or (b) had a permanent and total disability at the time of death; and (3) a person who died in the active uniformed service in the line of duty and not due to his own misconduct.²⁸

Section 1781 does not include a statutory right of reimbursement.²⁹ However, the statute authorizes the Secretary of Veterans Affairs to prescribe regulations governing the provision of medical care by contracting “for such insurance, medical service, or health plans as the Secretary deems appropriate.”³⁰ The regulations promulgated by the Secretary of Veterans Affairs specifically provide that “[s]ervices and supplies required as a result of an occupational disease or injury for which benefits are payable under workers’ compensation or other similar protection plan (whether or not such benefits have been applied for or paid)” are excluded from CHAMPVA coverage.³¹ The regulations also provide that HAC “will activity pursue third-party liability/medical care cost recovery in accordance with applicable law.”³² Based upon these federal regulations, HAC pursues recovery of payments for medical services and supplies provided to CHAMPVA beneficiaries in workers’ compensation cases.³³

If the plaintiff in a workers’ compensation claim received medical care under CHAMPVA, notification may be made to:

Department of Veterans Affairs
Health Administration Center
Post Office Box 65022
Denver, Colorado 80206-9022
Phone: (800) 733-8387

F. Medicare

²⁷ 38 U.S.C. § 1781(a).

²⁸ 38 U.S.C. § 1781(a). For purposes of CHAMPVA, the term “child” means a child younger than 18 unless the child is a full-time student who incurs a disabling illness or injury. 38 U.S.C. § 1781(c).

²⁹ 38 U.S.C. § 1781.

³⁰ 38 U.S.C. § 1781(b)(2).

³¹ 38 C.F.R. § 272.

³² 38 C.F.R. § 277.

³³ OHI (Other Health Insurance), Chapter 3, Section 4.1, CHAMPVA Policy Manual (11/28/06), <http://www.va.gov/hac/forbeneficiaries/champva/policymanual/cvampchap3/1c3s4.1.pdf>

The United States can recover from a third party or a Medicare beneficiary the value of Medicare payments made for which a third party is responsible.³⁴ The government has the following sources of authority for this right of recovery: the Medicare secondary payor statute, 42 U.S.C. § 1395y *et seq.*; enabling regulations, Title 42 part 411, Subpart B, § 411.20 *et seq.*; and Social Security Administration guidelines, such as the *Programs Operation Manual Systems (POMS)*, the Medicare Fiscal Intermediary Manual, the Medicare Carriers Manual, and memoranda that have been published by the Centers for Medicare and Medicaid Services (CMS). Relevant portions of the statute and regulations are attached at the end of this manuscript in an appendix.

The statute provides that Medicare is “secondary” to a “workmen’s compensation law or plan,” which is considered the “primary plan.”³⁵ Medicare may make conditional payments to Medicare beneficiaries who have workers’ compensation claims, and the Medicare secondary payor regulations give CMS the authority to initiate direct proceeding against an employer, carrier, or Medicare beneficiary for reimbursement of payments made to treat work-related injury of a Medicare beneficiary.³⁶ The regulations also provide for the reimbursement of Medicare of its lien from a compromise settlement agreement.³⁷

1. How to determine the amount of the lien.

If it appears that Medicare has paid for treatment of an arguably work-related injury in either an accepted or denied claim, it is in both parties’ interest to obtain complete information about the amount that Medicare may claim as a lien. For claimant’s attorneys, this information may be obtained by writing to the Medicare Coordination of Benefits Contractor at the following address:

Medicare-Coordination of Benefits (COB) Contractor
MSP Investigation Unit
P.O. Box 5041
New York, NY 10274-0125

You may also call the COB office at 1-800-999-1118 between 8:00 a.m. and 8:00 p.m. EST, Monday through Friday. When you contact the COB office, you will need to have your client’s HIC number, which is not exactly the same as the client’s social security number. The easiest way to get the number is from the client’s Medicare card.

After the COB office sets up the claim, it will assign a lead contractor to the file, and will send the claimant’s attorney a “Medicare Right of Recovery” letter and a

³⁴ This discussion is merely an overview of Medicare liens in workers’ compensation cases. Previous authors have given this topic more exhaustive treatment and their papers are still timely. For an excellent treatment of this topic, see Mark T. Sumwalt and Richard B. Harper, “Medicare, Medicare, and More Medicare (or, Things that Go “Bump” In Your Workers’ Compensation Case), North Carolina Bar Association Workers’ Compensation Section Annual Meeting, February 21, 2003.

³⁵ 42 U.S.C. § 1395y(b)(2)(A)(ii).

³⁶ 42 C.F.R. § 411.24(b), (e), (g).

³⁷ 42 C.F.R. § 411.46; 42 C.F.R. § 411.47.

“Release of Information” form for the beneficiary’s signature. The lead Medicare Recovery contractor is then supposed to create a Medicare Secondary Payer record in the CMS data base used in the claims adjudication process to prevent mistaken Medicare Primary payment for affected beneficiaries. Also, the COB Contractor is supposed to notify the lead recovery contractor of the attorney’s representation. The lead recovery contractor is then suppose to attempt to identify which claims that were paid by Medicare in relation to the work-related injury.

What happens in fact is a serious of confusing and bungled communications to the claimant’s attorney’s office, usually involving repeated requests for the claimant’s signature on release of information forms (our office has received as many as 5 duplicate requests) and repeated claims by the Medicare Recovery Contractor that Medicare has paid for services related to alleged work-related injuries that occurred on dates bearing no relation to the claimant’s actual work-related injury. Note that if you are a claimant’s attorney it is extremely important that you respond to all inquires from Medicare-related agencies, since the regulations require a duty to cooperate on the part of the beneficiary and provide that absent cooperation, CMS may seek recovery from the beneficiary.³⁸ As of the writing of this paper, the lead Medicare Recovery Contractor for our area is:

MSPRC
PO Box 33828
Detroit, MI 48232-3828

After you have sent in your client’s signed release, you will receive a conditional payment letter from CMS. Once you receive this letter, it is very important that you **review each item of expense carefully**. There is just no way around this. You will find that Medicare wishes to be reimbursed for the treatment they afforded the injured worker for the emergency department treatment for chest pain he received two years after his work-related back injury.

If the workers’ compensation claim is accepted, the Medicare Recovery Contractor should be notified immediately to submit it to the workers’ compensation carrier. If the claim is denied, both parties should keep careful track of the amount of the lien.

2. Waiver or reduction of the lien.

Medicare regulations definitely provide for reduction from the lien for procurement costs.³⁹ The regulations also provide for a reduction of the lien where a settlement makes a reasonable allocation between a wage lose and medical expenses and it is possible to determine the total amount that would have been payable under a workers’ compensation act absent compromised of the injured worker’s claim.⁴⁰ 42 C.F.R. § 411.47 seems to permit an allocation even where a settlement does not give

³⁸ 42 C.F.R. § 411.23(a), (b).

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reasonable recognition to both elements of a workers' compensation award or does not apportion the sum that is granted; however, CMS may not agree that apportionment is permitted under these circumstances.

3. What is the statute of limitations that limits the amount of time in which CMS may seek reimbursement of its lien?

42 U.S.C. § 1395y(b)(2)(B)(v) provides: claims-filing period. Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entities required or responsible under this subsections to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year beginning on the date on which the item or service was furnished. This would seem to put a 3-year limitation period on recovery by the government.

4. Who is responsible for payment of Medicare's lien?

The Medicare secondary payer statute gives CMS the power to hold a workers' compensation carrier and a self-insured employer for reimbursement of conditional payments made to treat work-related injuries 42 U.S.C. § 1395y(b)(2)(B)(ii). The statute also provides that "an entity that receives payment from a primary plan shall reimburse" Medicare for any payments made that should appropriately made by the primary plan. The statute provides that if reimbursement is not made within 60 days of notice of the primary plan's responsibility of such payment, the secretary may charge interest beginning with the date on which the notice or other information is received. This statute certainly seems to give CMS the power to hold a medical provider responsible if it had submitted a bill under Medicare that it knew should have been submitted to a workers' compensation carrier, or if it fails to rectify the situation once it receives notice of its obligation.

5. Who can enforce the government's subrogation interest?

Medicare Secondary Payer Act also provides for a private right of action, giving the injured worker a right to bring an action against a primary plan which fails to provide for payment of work-related medical bills which have fallen to Medicare. As with an action brought by the United States, the plaintiff is entitled to double damages 42 U.S.C. § 1395y(b)(2)(B)(iii) and 42 U.S.C. § 1395y (b)(2)(B)(iii).

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subparagraph where the request for payment is submitted to the entities required or responsible under this subsections to pay with respect to the item or service (or any portion there of) under a primary plan within the 3-year beginning on the date on which the item or service was furnished. This would seem to put a 3-year limitation period on recovery by the government. However, _____.

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III. STATE STATUTORY LIENS

A. State Employee Health Plan

There are currently over 560,000 members in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (the Plan).⁴¹ The Plan covers all employees of the state, teachers, and miscellaneous other government employees and their spouses and families for whom dependent coverage is elected.

On July 20, 2004 the North Carolina Legislature created a lien on proceeds received from third-party funds by plan members and their dependants. The lien was amended on August 27, 2006 with all changes effective on that date. On that same date, the wrongful death statute was also amended to exclude the Plan from the \$4,500.00 cap on recovery of medical expenses.⁴² The Plan liens statute provides the following:

§ 135-40.13A. Liability of third person; right of subrogation; right of first recovery.

⁴¹ N.C.Gen. Stat § 135-1 *et seq.*

⁴² N.C.Gen. Stat § 28A-18-2(a).

(a) Whenever the Plan pays benefits for hospital, surgical, medical, or prescription drug expenses, with respect to any Plan member, the Plan shall be subrogated, to the extent of any payments under the Plan, to all of the Plan member's rights of recovery **against liable third parties**, regardless of the entity or individual from whom recovery may be due. The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan **has** the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery to the extent allowed by law pursuant to G.S. 135-40.13(g). If the Plan recovers **damages** from a liable third party in excess of the **claims** paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a **liable third party** to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for not more than the value of claims paid related to the **liability of the third party**, on **any** damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) 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. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney, and the attorney **shall** disburse proceeds pursuant to this section."

The statute was drafted for the purpose of enabling the Plan to obtain subrogation in the context of tort claims, and not workers' compensation claims. Thus the language

“liable third party” was chosen deliberately, as it mirrors the language of the third-party liability statute, N.C. Gen. Stat. § 97-10.2. Moreover, the term “damages” is used in tort claims as opposed to workers’ compensation claims.

B. Medicaid—N.C. Gen. Stat § 108A-57

Medicaid is a federal-state government program of medical assistance for persons eligible due to financial need that is authorized by Title XIX of the Social Security Act.⁴³ In North Carolina, the program is administered by the Department of Health and Human Services, Division of Medical Assistance (DMA).⁴⁴ The Third Party Recovery Section (TPR) of DMA is responsible for identifying sources of reimbursement for Medicaid and seeking reimbursement from those sources.⁴⁵

N.C. Gen. Stat. § 108A-57 provides that to the extent of all Medicaid payments made on behalf of the Medicaid beneficiary, North Carolina is “subrogated to all rights of recovery, contractual or otherwise, of the beneficiary . . . against any person.”⁴⁶ This statute applies to recoveries in a workers’ compensation case. However, in cases in which a beneficiary’s attorney receives funds “from a third party by reason of injury or death,” Medicaid’s right of subrogation is limited to “one-third of the gross amount obtained or recovered” and must be “prorated with the claims of all others having medical subrogation rights or medical liens against the amount obtained or recovered.”⁴⁷

The statute expressly provides that a beneficiary’s attorney is responsible for “enforcing” Medicaid’s right of subrogation: “an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made . . . shall enforce this section.”⁴⁸

*Ezell v. Grace Hospital, Inc.*⁴⁹ involved a medical malpractice suit brought on behalf of a minor child, alleging that the plaintiff’s cerebral palsy was the result of defendants’ negligence immediately following her birth. After credible evidence revealed problems with causation, plaintiff settled with the defendants for \$100,000.00.⁵⁰ DMA intervened, claiming \$86,840.92 Medicaid lien for payments made on behalf of plaintiff. The trial court found that only \$8,054.01 of Medicaid’s claim was for medical expenses causally related to defendants’ alleged negligence and limited DMA’s recovery to \$8,054.01, rather than \$33,333.33. The North Carolina Court of Appeals vacated the trial court’s order and remanded the case for further findings after concluding that the

⁴³ 42 U.S.C. § 1396 *et seq.*

⁴⁴ N.C. Gen. Stat. § 108A-54 *et seq.*

⁴⁵ Each state Medicaid program is required to ascertain the legal liability of third parties to reimburse for medical assistance provided by the state and recover from third parties the cost of medical assistance provided. 42 U.S.C. § 1396a(a)(25).

⁴⁶ N.C. Gen. Stat. § 108A-57(a).

⁴⁷ N.C. Gen. Stat. § 108A-57(a).

⁴⁸ N.C. Gen. Stat. § 108A-57(a).

⁴⁹ 175 N.C. App. 56, 623 S.E.2d 79 (2005).

⁵⁰ Plaintiff and the hospital settled early in the case for \$100,000.00 and the trial court had previously approved this settlement.

trial court's findings on causation were not supported by competent evidence. In writing for the majority, Judge Hudson stated that the legislature "surely did not intend that DMA could recoup for medical treatment unrelated to the injury for which the beneficiary received third-party recovery."⁵¹

Judge Steelman dissented, reasoning that because section 108A-57 "entitles the State to full reimbursement for any Medicaid payments made on plaintiff's behalf in the event that the plaintiff recovers an award for damages" and "does not restrict [DMA's] right of subrogation to a beneficiary's right of recovery only for medical expenses," it is "irrelevant whether a settlement compensated a plaintiff for medical expenses."⁵² He agreed that "no DMA lien would attach to proceeds of a settlement from an automobile accident for Medicaid payments for unrelated cancer treatments," but concluded that DMA was subrogated to the entire amount of the settlement since the settlement arose directly from a claim of medical malpractice that allegedly caused plaintiff's cerebral palsy.⁵³ Judge Steelman also noted that "[o]ur cases have consistently rejected attempts by plaintiffs to characterize portions of settlements as being for medical bills or for pain and suffering in order to circumvent DMA's statutory lien."⁵⁴ Thus, in Judge Steelman's view, DMA was entitled to receive one-third of \$100,000.00 as partial payment of its \$86,540.92 lien.

DMA appealed, and on June 30, 2006, the North Carolina Supreme Court issued a *per curiam* opinion reversing the Court of Appeals' decision in *Ezell* "for the reasons stated in the dissenting opinion."⁵⁵ To the extent that the North Carolina Supreme Court's decision in *Ezell* holds that Medicaid can assert its right of subrogation under section 108A-57 against portions of a settlement that compensates a Medicaid beneficiary for non-medical damages (e.g., lost earnings, permanent injury, and scarring), it is inconsistent with the United States Supreme Court's decision in *Arkansas Department of Health and Human Services v. Ahlborn*,⁵⁶ which was published on May 1, 2006.

Heidi Ahlborn was seriously injured in an automobile accident and filed a personal injury lawsuit to recover damages, including past and future medical expenses, permanent injury, pain and suffering, lost earnings, and permanent impairment of future earnings capacity. The Arkansas Department of Health and Human Services (ADHS) intervened to assert a lien in the amount of \$215,645.30 for Medicaid payments for Ahlborn's medical care related to the accident. Ahlborn settled the lawsuit for \$550,000.00, with no allocation of damages.

Ahlborn then filed a declaratory judgment action in federal court seeking a declaration the Medicaid lien violated the federal Medicaid statute to the extent it applied to the portion of a personal injury settlement that compensated a Medicaid beneficiary for

⁵¹ 175 N.C. App. at 61, 623 S.E.2d at 82.

⁵² 175 N.C. App. at 64, 623 S.E.2d at 84 (dissent).

⁵³ 175 N.C. App. at 65, 623 S.E.2d at 84 (dissent).

⁵⁴ 175 N.C. App. at 65, 623 S.E.2d at 85 (dissent).

⁵⁵ 360 N.C. 529, 631 S.E.2d 131 (2006), *reversing* 175 N.C. App. 56, 623 S.E.2d 79 (2005).

⁵⁶ 126 S.Ct. 1752 (2006).

damages other than past medical expenses. The parties stipulated that the entire claim was reasonably valued at \$3,040,708.12, the settlement was approximately one-sixth of that sum; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to \$35,581.47, the portion of the settlement that constituted reimbursement for medical expenses. The district court held that the Medicaid lien was valid and enforceable in full. The Eighth Circuit reversed, holding that states can place a lien only on the portion of the settlement that represents payment for past medical expenses. The United States Supreme Court affirmed.

In *Arkansas Department of Health and Human Services v. Ahlborn*,⁵⁷ the Supreme Court unanimously held that the third-party liability provisions of the Federal Medicaid statute⁵⁸ did not authorize Arkansas' statute to the extent the statute applied to a Medicaid beneficiary's right to payment for damages for personal injury other than compensation for medical expenses. The Court also concluded that the Arkansas statute violated the federal Medicaid law's anti-lien provision, 42 U.S.C. § 1396p(a)(1), which prohibits state Medicaid programs (with some exceptions not relevant to third-party liability claims) from imposing liens against the property of Medicaid beneficiaries. The Court held, therefore, that Arkansas' Medicaid lien could not exceed the portion of the settlement that constituted reimbursement for medical payments made (\$35,581.47).

To the extent that section 108A-57 or the North Carolina Supreme Court's decision in *Ezell* apply to Medicaid beneficiary's right to recover payments from a third party for damages other than medical expenses that have been covered by North Carolina's Medicaid program, they are inconsistent with the federal Medicaid statute and the *Ahlborn* decision. Since federal Medicaid law will preempt state law, it would appear that *Ezell* may not be good law.

Until the conflict between *Ezell* and *Ahlborn* is resolved, practitioners can use the *Ahlborn* decision during negotiations to reduce the amount claimed by TPR. If TPR refuses to negotiate in a case where the Medicaid lien would unduly deplete Medicaid's recovery, *Ahlborn* supports a declaratory judgment action in federal court. Moreover, pursuant to N.C. Gen. Stat. § 97-17, it may be possible for practitioners ask the North Carolina Industrial Commission to set the amount to which TPR is entitled.

If a workers' compensation claim involves a plaintiff who received medical care paid for by Medicaid, it is necessary to contact TPR to determine if there is a lien. The contact address and telephone number for TPR are:

Third Party Recovery Section
Division of Medical Assistance
2508 Mail Service Center
Raleigh, NC 27699-2508
Phone: (866) 677-7220

⁵⁷ 126 S.Ct. 1752 (2006).

⁵⁸ Specifically, the assignment provisions of 42 U.S.C. § 1396k and the anti-lien provisions of 42 U.S.C. § 1396a(a).

C. Vocational Rehabilitation—N.C. Gen. Stat. § 143-547

Pursuant to N.C. Gen. Stat. § 143-547, North Carolina has a subrogation right to payments made by the Division of Vocational Rehabilitation for rehabilitation services. If a person receives rehabilitation services, “the State Vocational Rehabilitation program shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of assistance, or his personal representative, his heirs, or the administrator or executor of his estate, against any person.”⁵⁹ The statute specifically includes workers’ compensation recoveries.⁶⁰

Priorities for payment are as follows:

- (1) First to the payment of any court costs taxed by the judgment;
- (2) Second to the payment of the fee of the attorney representing the beneficiary . . . , but this fee shall not exceed one-third of the amount obtained or recovered to which the right of subrogation applies;
- (3) Third to the payment of the amount of assistance received by the beneficiary as prorated with other claims against the amount obtained or received from the third party to which the right of subrogation applies, but the amount shall not exceed one-third of the amount obtained or recovered to which the right of subrogation applies; and
- (4) Fourth to the payment of any amount remaining to the beneficiary or his personal representative.⁶¹

The right to subrogation only applies in cases where a financial needs test was administered as a condition to receipt of benefits; therefore, services provided without a financial needs test are excluded.⁶²

The Division of Vocational Rehabilitation Services may agree to waive subrogation rights.⁶³

If a workers’ compensation plaintiff has received rehabilitation services from the Division of Vocational Rehabilitation Services, it is necessary to contact the local Rehabilitation Office. The address and telephone number for each local office is located at the following web site: <http://dvr.dhhs.state.nc.us/DVR/offices/iloffices.htm>.

⁵⁹ N.C. Gen. Stat. § 143-547(a).

⁶⁰ N.C. Gen. Stat. § 143-547(b)(2).

⁶¹ N.C. Gen. Stat. § 143-547(a).

⁶² N.C. Gen. Stat. § 143-547(c).

⁶³ N.C. Gen. Stat. § 143-547(d).

D. Crime Victims Compensation Fund—N.C. Gen. Stat. § 15B-18

Through the North Carolina Crime Victims Compensation Act, N.C. Gen. Stat. § 15B-1 *et seq.*, North Carolina established a Crime Victims Compensation Fund, which helps compensate victims of crime recover the costs of medical care and lost wages that the victims incur as the result of criminal activity.

North Carolina has a subrogation right to payments made pursuant to this Act.⁶⁴ Specifically, under N.C. Gen. Stat. § 15B-18, if a victim is compensated for expenses resulting from a crime-related injury, “the Crime Victims Compensation Fund is subrogated to all of the claimant’s rights to receive or recover benefits or advantages for economic loss from a source that is, or if readily available to the victim or claimant would be, a collateral source, to the extent of the compensation awarded.”⁶⁵

The claimant must give the Crime Victims Compensation Commission written notice prior to bringing an action to recover damages related to criminal activity for which compensation is claimed or awarded.⁶⁶ After receiving notice, the North Carolina Attorney General will join the action as a party plaintiff, require the claimant to bring the action as a trustee of the state, or reserve its rights in the proposed action.⁶⁷

The contact address and telephone number for Victims Compensation Services are:

NC Department of Crime Control and Public Safety
Victims Compensation Services
4703 Mail Service Center
Raleigh, NC 27699
Phone: (800) 826-6200

IV. CONCLUSION

⁶⁴ N.C. Gen. Stat. § 15B-18.

⁶⁵ N.C. Gen. Stat. § 15B-18(a).

⁶⁶ N.C. Gen. Stat. § 15B-18(c).

⁶⁷ N.C. Gen. Stat. § 15B-18(c).