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RIGHT OF RECOVERY AGAINST MEDICARE FOR PRE-DECEMBER 5, 1980 MOTOR VEHICLE ACCIDENTS

Lori Ittner¹ – Contributor

In the context of pursuing reimbursement against Medicare for claims that they should be issuing payment for, the effective date of the Medicare Secondary Payor Statute becomes critical. Much confusion has arisen regarding the fact that the amendment was signed into law by President Carter on December 5, 1980 and the fact that the U.S. Department of Health and Human Services, the entity responsible for regulating the Medicare Secondary Payor Statute, did not publish their official regulations until June 6, 1983. Therefore, many believe that June 6, 1983 was the effective date of the statute. In fact, the effective date of the statute is the date that it was signed by President Carter irrespective of when the Code of Federal Regulations was published. The Code of Federal Regulations is nothing more than implementation guidelines and cannot control to the extent that they conflict with the statute itself.

Much discussion has been held over the decision by the Michigan Supreme Court in the case of *LeBlanc v State Farm*, 410 Mich 173 (1981) and the fact that a portion of the *LeBlanc* decision was overruled. The important portion of the *LeBlanc* decision, that being when Medicare would be primary for pre-December 5, 1980 motor vehicle accident benefits, was not. In fact, *LeBlanc* examined Medicare benefits to determine whether they were governmental benefits that should

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be subtracted from benefits otherwise payable by no fault under MCL 500.3109 or whether in fact they were other health and accident coverage which the no fault insurer was entitled to coordinate at a reduced premium to the insured, pursuant to MCL 500.3109(a). The case made it abundantly clear that Medicare benefits are in fact other health and accident coverage by the very nature of the type of benefit payments allowed by the statute and, therefore, in order for a no fault insurer to consider Medicare payments for pre-December 5, 1980 motor vehicle accidents, there must be a coordinated policy of insurance.

In this context, it is clear that in order for a no fault insurer to pursue reimbursement of amounts paid in error for which Medicare should have been paying on a primary basis, there must be a coordinated no fault policy of insurance. The statutory basis that allows a cause of action against the Federal Government for money damages is the Federal Tort Claims Act. That Act allows a proceeding against the Federal Government, as set forth above, for monetary damages and can be based upon a state cause of action for which the Federal Government would be subject to. In this context, not only does the Michigan No Fault Act make it clear that the Federal Government would be primary for payment of benefits, but so too does 42 CFR § 411.50 which indicates that the provisions of sub-part (c), which would be the provisions concerning limitations on Medicare's payments for services covered under such things as no fault policies, do not apply to any services required because of accidents that occurred before December 5, 1980. In this context, Medicare makes it clear that they recognize that they are primary for pre-December 5, 1980 accidents and the treatment resulting therefrom.

In the context of the ability to pursue reimbursement against Medicare for pre-December 5, 1980 motor vehicle accidents, it is incumbent upon each no fault insurer to examine all of their claims and determine which ones may fall into this category. Thereafter, a very careful analysis of the facts and circumstances existing must be undertaken on an immediate basis. Thereafter, recommendation is made for immediate commencement of litigation not only to seek money damages, but also to seek a determination by Medicare that they must immediately commence payment of claims on a primary basis based upon the date of loss, and an administrative record must be created whereby a request for reimbursement is made to Medicare by way of submission of specific documentation covering the six year period, and whereby a request thereafter is made under the Administrative Procedures Act, that a reversal and acknowledgment of the primary status of Medicare immediately commences. Also, claims for money damages are governed by the Federal Tort Claims Act. Both acts make it clear that this administrative request is absolutely fundamentally necessary before litigation can be commenced. There is no shortcut to submission of a complete record and complete claims file documentation is absolutely necessary in order to support, once litigation has commenced, that the no fault insurer is not only entitled to reimbursement of money damages, but is also entitled to an evaluation of the procedure utilized by Medicare in their refusal to commence payment on a primary basis under the Administrative Claims Procedure Act.

CONCLUSION

In conclusion, it is critical to review each and every claim whose accident date is prior to December 5, 1980 to determine whether or not Medicare is paying on a primary basis or whether

or not the no fault insurer is otherwise entitled to reimbursement. Again, the statute of limitations for pursuing action against the Federal Government, and the need to create an administrative record, makes it clear that immediate proactive action is fundamentally necessary.

ELIMINATING THE MYTH OF MEDICARE RECOVERY PROGRAMS AND ADDRESSING THOSE PROGRAMS WITH PROACTIVITY

Lori Ittner² – Contributor

An action by Medicare that is becoming far too familiar to no fault insurers is Medicare's request for reimbursement to a no fault insurer for amounts that Medicare deems to have been paid in error. Often an initial notification is received from Medicare which simply indicates that Medicare may have made a conditional payment in error and they are notifying the no fault insurer that a lien exists in the event it is determined that a payment was made in error. This is often a no fault insurer's first notification that Medicare is issuing payments to and on behalf of an insured at the same time that a no fault insurer may be issuing payments on behalf of that insured for accident related treatment. The next notification received, in most instances, is simply a letter to the no fault insurer asking for reimbursement for a specific dollar amount and may or may not be accompanied by an itemized payment listing.

It is simply not enough for a no fault insurer to forward a letter to Medicare at that time indicating that they need additional information, nor is it sufficient to simply indicate that a no fault insurer only pays for reasonably necessary products, services and accommodations for an injured person's care, recovery and rehabilitation and nothing more. Often, a no fault insurer will respond that benefits are not due and owing until 30 days after receipt of reasonable proof of the fact and of the amount of loss sustained pursuant to MCL 500.3142. The difficulty with this response lies in the fact that Medicare exists by virtue of a Federal statute and, therefore, to the extent that a no fault statute conflicts with that statutory Federal mandate, the no fault statutory provision is preempted.

The right of Medicare to recover for benefits paid in error is based upon the Omnibus Reconciliation Act of 1980, found at 42 USCA 1395y, and which is commonly referred to as the Medicare Secondary Payor statute. Both the Medicare Secondary Payor statute and the Code of Federal Regulations, more particularly, CFR 411.20, make it clear that Medicare is not primary for payment to the extent that payment has been made or can reasonably be expected to be made by a no fault insurer. The Act itself, particularly §1862(b)(2)(A)(ii), precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made by a no fault insurer.

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The Medicare Secondary Payor statute makes it clear that if a no fault insurer or other third party is aware of the fact that Medicaid has made a conditional payment in error, they are under a direct obligation to immediately refund Medicare within 60 days or Medicare is entitled to interest. The 60 day period from which interest applies begins on the date on which notice or other information is received by CMS that payment has been made or could have been made by a primary plan. That interest is charged until reimbursement is made and is applied for full 30 day periods and not partial periods. In essence, Medicare does not have to provide anything other than notice that it is their belief that payments were made in error and seek reimbursement. It is incumbent upon the no fault insurer to conduct a thorough investigation so as to determine which benefits from the payment listing are reimbursable and which are not based upon some determination that they were payments for a pre-existing or concurrent medical condition, or certainly, to stand on the position that the insured has received maximum medical improvement and payments are no longer due and owing. This must be done by submission of documentation and must be done in a swift fashion.

There are several ways that Medicare can recover against a no fault insurer for amounts they deem to have been made in error. One such way is by filing an action against the no fault insurer under the Medicare Secondary Payor statute or by subrogating their right to pursue recovery against the no fault insurer by notice of a lien to your insured, in the event the insured seeks the utilization of the private cause of action enforcement provision found within the statute itself. The enforcement provision provides the ability of a claimant to file litigation on behalf of the government for Medicare reimbursement, allows the government to enjoy the same remedies and allows recovery of double damages (i.e., each and every bill that Medicare paid in error), actual attorneys fees and costs. There is also a provision in the Code of Federal Regulations, CFR 411.24, that is used by Medicare as an enforcement tool in their recovery program. That Code provision makes it clear that CMS may recover without regard to any claims filing requirements that an insurance program imposes on a beneficiary or claimant. This provision also places both the beneficiary and any primary plan (a no fault insurer) on notice that CMS may employ the offset program for recoupment purposes. Obviously, there are issues related to due process since this occurs without a judgment, however, those are issues to be addressed by a court. The important issue is the fact that Medicare is utilizing this program to automatically withdraw funds from a no fault insurer's account.

In the context of Medicare's request for reimbursement, and a response by the no fault insurer, there is also a fundamental legal basis for undertaking an immediate response to the request for reimbursement. That legal basis lies in a no fault insurer's ability to dispute in a court of law a request by Medicare for reimbursement of amounts they paid for non-accident related treatment or a carrier's right to seek reimbursement of amounts Medicare automatically withdrew pursuant to the Federal offset program. The first such provision is the Federal Tort Claims Act which is the Federal statute by which every civil action may be commenced against the United States for monetary damages. The second is the Administrative Claims Procedure Act which allows equitable relief by way of a no fault insurer's request that the Federal courts evaluate the procedure utilized by Medicare. Both contain similar limitations on actions against the Federal Government and procedures that must be complied with administratively before an action may be

commenced. The failure to comply with these rules and the failure to respond to such a request for reimbursement in a timely fashion lead to the ultimate conclusion to such ability to recover automatic withdrawn funds and the ability to dispute the reimbursement will be forever barred. Therefore, a program designed to respond to such requests, create an administrative record, and timely pursue remedies is critical and should be developed by each and every carrier.

**COURT OF APPEALS HOLDS THAT CONSENT TO
SETTLE PROVISION IN UNINSURED MOTORIST
BENEFITS POLICY CAN BE WAIVED BY INSURER**

Megan Cavanagh³ – Contributor

An insurer defending against a first-party action for benefits – whether they be uninsured motorist benefits, property loss benefits or homeowners liability benefits – is well advised to monitor and protect its subrogation rights at all stages of the litigation. A recent decision by the Michigan Court of Appeals confirms that an insured who settles his claim with the tortfeasor by accepting case evaluation jeopardizes coverage by prejudicing the insurer's subrogation rights under its insurance policy. However, in order for the insurer to preserve its ability to rely upon the policy's subrogation provision to deny coverage, the insurer cannot turn a blind eye to the settlement but must actually put the insured on notice of its intent to assert its subrogation rights. This notice should be given as soon as the insurer receives notice of its insured's intent to settle. An insurer who continues to litigate the first-party claim after the insured has settled with the tortfeasor bears the risk of waiving its subrogation rights.

In *Suminski v State Farm Mut Auto Ins Co*, unpublished per curiam decision (Docket No. 273947, February 14, 2008), the Michigan Court of Appeals recently held that a written consent to settle provision in an uninsured motorist benefits policy may be enforced against an insured who settles with the at-fault driver by accepting a case evaluation award. However, under the facts of this case, the Court held that the insurer waived its subrogation rights when it failed to assert those rights after learning of its insured's intent to accept the case evaluation award against the at-fault driver. The plaintiff was injured in an automobile accident when she was rear-ended by an uninsured driver. Plaintiff filed suit against the driver and later amended her complaint to add a claim for recovery of uninsured motorist benefits against her insurer. The case proceeded to case evaluation and an award of \$85,000 was rendered in plaintiff's favor. \$80,000 of the award was attributed to the insurer and \$5,000 was attributed to the at-fault driver. Plaintiff and the at-fault driver both accepted the case evaluation award and a judgment was entered against the driver for \$5,000.

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Plaintiff's uninsured motorist benefits claim proceeded against her insurer. The parties stipulated to adjourn trial and participate in facilitation. The insurer offered to settle for \$95,000 - representing its policy limits minus a \$5,000 setoff for the settlement with the driver. However, the insurer informed the plaintiff that the offer was conditioned on plaintiff not having released the at-fault driver. Plaintiff accepted the insurer's offer to settle the case. However, at some point thereafter, the insurer disputed its liability under its policy, claiming that Plaintiff had failed to obtain the insurer's written consent prior to settling her claim with the driver.

Plaintiff filed a motion to enforce the parties' purported settlement agreement. The insurer responded by denying the existence of a binding settlement agreement and by asserting that plaintiff was precluded from recovering benefits because she failed to obtain the insurer's written consent to settle with the driver. The trial court held that no binding settlement agreement existed but rejected the insurer's claim that plaintiff improperly released its subrogation rights. The trial court held that the policy provision requiring written consent did not apply in the context of a settlement involving the acceptance of a case evaluation award. The insurer appealed.

The Court of Appeals affirmed the trial court, although for different reasons. The Court held that the policy's written consent provision did apply in the context of a settlement involving the acceptance of a case evaluation award because plaintiff's acceptance of the award against the driver was reduced to a final judgment that had the effect of fully adjudicating plaintiff's claims against the driver. However, the Court concluded that, despite the applicability of the written consent provision of the policy, the insurer had waived that requirement. The Court found that the insurer had received notice that plaintiff and the driver had accepted case evaluation but did step forward to invoke the written consent provision of the policy. Further, the insurer was specifically asked whether it had any objection to entry of the judgment against the at-fault driver but the insurer again did nothing to invoke the provision. Importantly, the Court concluded that the insurer's decision to continue litigating the claim, including participating in facilitation, constituted acts and conduct from which waiver could and should be inferred. Accordingly, the Court of Appeals affirmed the trial court and held that the insurer had waived its right to enforce the written consent provision of its policy.

In light of this opinion, an insurer should be sure to assert its subrogation provision as a bar to coverage as soon as the insurer receives notice of its insured's intent to settle with the tortfeasor. Continuing to litigate the claim for benefits without having asserted the policy's subrogation provision, could potentially waive the insurer's ability to raise the provision as a bar to coverage. An insurer who receives notice of the insured's *intent* to settle, i.e., by receiving notice of the insured's acceptance of case evaluation, should warn the insured of the consequences of that action to coverage. If the insurer does not receive notice of the settlement until after it has already occurred, the insured should not dely in bringing the appropriate motion to assert the subrogation provision and seek dismissal of the insured's claim for benefits.

BUCKEYE SEMINAR

The Firm's annual seminar in Ohio will be held on March 12, 2008 at the Greater Columbus Convention Center in Columbus, Ohio. An agenda for this event is as follows:

- 8:00 - 8:30 a.m. Continental Breakfast
- 8:30 - 8:40 a.m. Welcome and Introduction
Speaker: Susan Williams
- 8:40 - 9:40 a.m. Michigan Automobile No Fault - First Party Update
Speaker: Edward Freeland
- Coverage
 - "Arising Out Of"
 - Allowable Expenses
 - Government Benefits/Liens
 - Order of Priority
 - Statute of Limitations
 - Attorney Fees and Interest
- 9:40 - 10:30 a.m. Northern Michigan Recreational Accidents
Speaker: Peter Worden
- Land based accidents
 - Skiing
 - Off Road Vehicles
 - Snowmobiling
 - Hunting
 - Fishing
 - Equine
 - Bicycling
 - Water based accidents
 - Michigan versus Maritime Law
 - Federal Maritime Law
- 10:30 - 10:45 a.m. Break
- 10:45 - 11:45 a.m. Michigan Third-Party Automobile Liability Updates
Speaker: Christopher Jelinek
- Statutory/Case Law Overview
 - Non-Party At Fault Rule
 - Threshold Requirements
 - Dispositive Motions
 - *Kreiner* and its Progeny
 - Court of Appeals/Supreme Court - Recent Rulings
 - Proposed Legislative Changes

- Uninsured Motorist/Underinsured Motorist Coverage
- 11:45 - 1:00 p.m. Lunch on Your Own
- 1:00 - 1:30 p.m. Catastrophic Claims
Speaker: Susan Williams
- MCCA
 - Guardianship Fees
 - Use of Case Managers and Other "Experts"
 - Attendant Care
 - Transportation Purchase Agreements
 - Home Modifications/New Building Agreements
- 1:30 - 2:30 p.m. Michigan Dram Shop Law
Speaker: Stacey King
- Michigan Case Law and Statutes
 - Representing the Owner versus AIP
 - Importance of Early Investigation
 - Use of Experts
 - Settlement Agreements
- 2:30 - 3:00 p.m. Questions and Answers

Please call or email Kristi Woloszyk at (248) 641-7600 or kwoloszyk@garanlucow.com for more information or to register.

GRAND RAPIDS BREAKFAST SEMINAR

The Firm is pleased to present its Annual Spring Breakfast Seminar on April 24, 2008 at the Frederik Meijer Gardens and Sculpture Park, located at 1000 East Beltline, NE in Grand Rapids [(616) 957-1580]. Comprehensive written materials will be distributed to all program attendees. After the seminar, feel free to enjoy all of the open indoor garden areas as our guest. The agenda for this event is as follows:

- 8:00 - 8:25 a.m. Registration and Continental Breakfast
- 8:25 - 8:30 a.m. Welcome and Introduction
Speaker: David N. Campos
- 8:30 - 9:00 a.m. Northern Michigan Recreational Accidents: An Overview of Civil Liability
* General Liability Principles for Landowners & Participants;
Governmental Immunity; Relationship with MVA Laws * Skiing

* Off Road Vehicles * Snowmobiling * Hunting * Fishing *
Equine Activities * Bicycling
Speaker: Peter B. Worden

9:00 - 9:20 a.m. Employment Law in Michigan
*Litigation: Claims, Statutes, The Legal Process * Litigation
Prevention: Handbooks, Policies & Record Keeping *
Employee Wellness Programs
Speaker: Aaron L. Belville

9:20 - 9:40 a.m. Impact of Medicare, Medicaid & SCHIP Extension Act of 2007
on PIP Claims
*Medicare Set-Aside Trusts: What Are They & When Are They
Used? *MSAs for Workers Comp, General Liability and No
Fault Claims
Speaker: Tara L. Velting

9:40 - 10:15 a.m. Michigan Third Party Automobile Liability Update
*Non-Party At Fault Rule * Threshold Requirements * *Kreiner*
and Its Progeny * Proposed Legislative Changes * Uninsured
Motorist/Underinsured Motorist Coverage
Speaker: Christopher P. Jelinek

10:15 - 10:30 a.m. Break

10:30 - 11:15 a.m. Michigan Auto No Fault First Party Update
* "Constructive Ownership" & Responsibility to Insure (or not)
a Motor Vehicle .3101 * Equitable Estoppel of One Year
Statute of Limitations .3145 * No Fault Insurer's Right to IME
.3151 & .3159 * Equitable Estoppel with Denial of Coverage
Relative to Failure to Disclose .3163 * Tort Liability Exposure
above PPI \$1 million .3121 * Business Use Exclusions
Enforceable with Auto, B.I. policy, *Bristol West v Butzbach*
Speaker: David N. Campos

11:15 - 11:45 a.m. Demonstration of an Orthopedic Exam
Speaker: Clifford M. Buchman, D.O.

11:45 a.m. - Noon Question and Answer Session

If you are able to attend this complimentary annual event, please register via email to:
lbeatty@garanlucow.com or phone Lynn Beatty at (616) 742-5500 or (800) 494-6312 for
reservations.

BASIC NO FAULT COURSE AT LTU

The Basic No Fault course will commence on Tuesday, May 13, 2008 and run through July 29, 2008. The classes will be at the Southfield campus of Lawrence Tech University. Please call Tim Meloche at (248) 204-4055 for additional information or to register for the course.