# Sources of Recovery and Liens

by

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**A. The Collateral Source Rule**

The collateral source rule has been referred to as an "oddity of American accident law" and "tort's soul." John G. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 Cal. L. Rev. 1478 (1966); Michael I. Krauss & Jeremy Kidd, *Collateral Source and Tort's Soul*, 48 U. Louisville L. Rev. 1 (2009). And "[s]ome have argued that the plaintiff might get a windfall if a jury is denied the right to know about the collateral sources, however, '[i]f there must be a windfall, it is usually considered more just that the injured person should profit, rather than let the wrongdoer be relieved of full responsibility for his wrongdoing. [Cit.]'" *Denton v. Con-Way S. Express*, 261 Ga. 41, 46 n. 5, 402 S.E.2d 269 (1991) (citing 22 AmJur2d 639, Damages, § 566), overruled on other grounds, 262 Ga. 374, 376, 418 S.E.2d 27 (1992). Regardless of which side you come down on, the collateral source rule is by far one of the most powerful tools a plaintiff has to maximize his recovery in a personal injury case. Every practitioner of personal injury law should understand its reach and implications.

The collateral source rule was introduced in Georgia in 1885 by Judge Samuel Lumpkin in *The Western & Atlantic Railroad v. Meigs*, 74 Ga. 857 (1885). *Polito v. Holland*, 258 Ga. 54, 55-56, 365 S.E.2d 273 (1988). "The collateral source rule is primarily substantive in nature. It gives a party the right to recover damages undiminished by collateral benefits. It refuses credit to the benefit of a tortfeasor of money or services received by the plaintiff in reparation of the

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injury or damage caused which emanate from sources other than the tortfeasor." *Id.* at 55. "[T]here are two consequences of the collateral source rule. One is substantive and is that damages are not reduced by the amount of collateral benefits plaintiff receives. The other consequence of the rule is evidentiary in effect. Because of the substantive consequence of the rule, evidence of collateral benefits is not generally material." *Id.* at 56.

The substantive application of the collateral source rule is that "[c]ollateral benefits does not reduce damages." *Id.* However, there are some exceptions to this part of the rule. The collateral source rule has been applied to prevent the jury from learning a defendant has already paid or written off the plaintiff's medical bills, but then the defendant may receive a credit toward the judgment to reduce a plaintiff's recovery. Because it is a "payment" by the defendant, it is not a true collateral source. In *Candler Hosp. v. Dent*, 228 Ga. App. 421, 491 S.E.2d 868 (1997), a medical malpractice case, the defendant hospital wrote off the plaintiff's medical bills. The court held that a "plaintiff can recover from the jury all special damages provable, but cannot receive in judgment again what has already been paid by the defendant or on the defendant's behalf by an insurer." *Candler Hosp.*, 228 Ga. App. at 423. The set-off in *Candler Hosp.* prevented a double recovery against the defendant. Additionally, medical bills that have been discharged in bankruptcy are properly allowed as proof of a plaintiff's damages, but are also to be "credited against a plaintiff's special damages for medical expenses." *Olariu v. Marrero*, 248 Ga. App. 824, 827, 549 S.E.2d 121 (2001).

The evidentiary part of the collateral source rule "bars the defendant from presenting any evidence as to payments of medical, hospital, disability income, or other expenses of a tortious injury paid for by a plaintiff, governmental entity, or third party and taking credit towards the defendant's liability in damages for such payments, because a tortfeasor is not allowed to benefit

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by its wrongful conduct or mitigate its liability by collateral sources provided by others." *Olariu*, 248 Ga. App. at 824.

The collateral source rule has been applied to exclude evidence of health insurance benefits, medical payments coverage, written off medical bills, medical bills discharged in bankruptcy, workers' compensation benefits, pension benefits, disability benefits, life insurance, and wage benefits. *Hammond v. Lee*, 244 Ga. App. 865, 536 S.E.2d 231 (2000) (workers' compensation benefits subject to collateral source rule); *Olariu*, 248 Ga. App. at 825-27 (medical bills written off and discharged in bankruptcy are collateral source evidence); *Southern R. Co. v. Cabe*, 109 Ga. App. 432, 440, 136 S.E.2d 438 (1964) (pension benefits); *Bennett v. Haley*, 132 Ga. App. 512, 524, 208 S.E.2d 302 (1974) (Medicaid benefits); *Edge v. Fugatt*, 264 Ga. App. 28, 29, 589 S.E.2d 845 (2003) (Social Security benefits); *Western & Atlantic Railroad v. Meigs*, 74 Ga. 857 (1885) (life insurance benefits); *Western & Atlantic R. Co. v. Sellers*, 15 Ga. App. 369, 83 S.E. 445 (1914) (wages paid by employer). *See also Cincinnati, New Orleans &c. R. Co. v. Hilley*, 121 Ga. App. 196, 201, 173 S.E.2d 242 (1970) (collecting cases and circumstances in which the collateral source rule has been applied).

The practitioner should be aware, however, of the exceptions to the collateral source rule in the evidentiary context. "[A] party may be impeached with collateral source evidence if the impeached testimony relates to a material issue." *Matheson v. Stilkenboom*, 251 Ga. App. 693, 696, 555 S.E.2d 73 (2001). *See also Kelley v. Purcell*, 301 Ga. App. 88, 686 S.E.2d 879 (2009). In *Matheson*, the plaintiff provided testimony that she did not treat because of the expense of the medical treatment. The defendant sought to introduce as impeachment evidence the fact that the plaintiff had health insurance that would have covered the treatment had the plaintiff sought treatment. *Id*. at 695-96. In another case, the Supreme Court found that the attempt to impeach

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the plaintiff with collateral source evidence was improper because it was not as to a material issue in the case. *Warren v. Ballard*, 266 Ga. 408, 410, 467 S.E.2d 891 (1996). *See also Worthy v. Kendall*, 222 Ga. App. 324, 325-26, 474 S.E.2d 627 (1996).

**B. Insurance Coverage**

In a personal injury suit, one of the most important things to find for an injured plaintiff is insurance coverage. There are many types of insurance coverage that may apply and each should be considered. Here is a non-exhaustive list:

Health insurance

Private insurance

Medicare

Medicaid

Peach Care

Champus

Tricare

FEHBA

Medical Payments Coverage

Workers' Compensation

Life Insurance

Unemployment

Short term / long term disability

Auto insurance

Liability – stacking

UM/UIM – stacking

Garage, CGL, Umbrella

Homeowners

Umbrella

Commercial General Liability

**C. Claims Against Recovery**

There can be many claims against a plaintiff's recovery in a personal injury case. Each should be thoroughly explored and addressed all parties.

1. Medicare

By law, 42 U.S.C. § 1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." However, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider, physician, or other supplier may bill Medicare as the primary payer. If the item or service is reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. Medicare Secondary Payer ("MSP") provisions make Medicare a secondary payer to certain non-group health plans ("NGHP"s), which include auto or other liability insurance, no-fault insurance, and workers' compensation plans. [1]

Medicare has an automatic lien and right to reimbursement for conditional payments made to or on behalf of beneficiaries. 42 U.S.C. § 1935y(b)(2)(A) and (B). Medicare will

[1] See, generally, http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Non-Group-Health-Plan-Recovery.html

consider arguments about relatedness of treatment and hardship claims. Medicare also applies a formula to reduce its claim by a proportional amount of attorney's fees and expenses that were required to obtain the recovery.

Medicare's Medicare Secondary Payer Recovery Contractor ("MSPRC") has been replaced by the Benefits Coordination & Recovery Center ("BCRC"). BCRC is now responsible for the recovery of the conditional payment of Medicare benefits that should have been covered by Liability, No-Fault, and Workers' Compensation (collectively referred to as Non-Group Health Plan or NGHP) insurance. Medicare's payments are considered "conditional" because they must be repaid to Medicare when a settlement, judgment, award, or other payment is made. The Medicare Secondary Payer Recovery Portal ("MSPRP") is a web-based tool designed to assist in the resolution of Liability Insurance, No-Fault Insurance, and Workers' Compensation Medicare recovery cases. You can still submit information through the mail or by fax as well. Current contact information can be found on the Centers for Medicare and Medicaid website: http://www.cms.gov. The MSPRP gives users (attorneys, insurers, beneficiaries, and TPAs) the ability to access and update certain case specific information online and monitor the recovery process online. You can access the portal at: https://www.cob.cms.hhs.gov/MSPRP/.

Whenever there is a pending liability, no-fault, or workers' compensation claim, it must be reported to the BCRC. BCRC then will collect information from multiple sources to research the MSP situation, as appropriate (e.g., information is collected from claims processors, MMSEA Section 111 Mandatory Insurer Reporting submissions, Initial Enrollment Questionnaire (IEQ), and Worker's Compensation carriers).

If the BCRC determines that the other insurance is primary to Medicare, they will create an MSP occurrence and post it to Medicare's records. If the MSP occurrence is related to a

NGHP, the BCRC uses that information as well as information from CMS' systems to identify and recover Medicare payments that should have been paid by another entity as primary payer.[2]

BCRC then initiates recovery activities against the responsible party and sends the beneficiary a Rights and Responsibilities ("RAR") letter. Within 65 days of the issuance of the RAR Letter, the BCRC will send a Conditional Payment Letter ("CPL") and Payment Summary Form ("PSF"). The PSF lists all items or services that Medicare has paid conditionally which the BCRC has identified as being related to the pending claim. The CPL provides information about how to dispute unrelated claims and includes the BCRC's estimate, as of the date the letter is issued, of the amount Medicare should be reimbursed (i.e., the interim total conditional payment amount).

If a settlement, judgment, award, or other payment has already occurred when the case is first reported to BCRC, a Conditional Payment Notice ("CPN") will be issued. This notice provides conditional payment information and advises the beneficiary on what actions must be taken. The beneficiary has 30 calendar days to respond.

When there is a settlement, judgment, award, or other payment, the beneficiary/representative should notify the BCRC and include: (1) the date of settlement, (2) the settlement amount, and (3) the amount of any attorney's fees and other procurement costs borne by the beneficiary.[3] BCRC will then calculate its final determination of the amount due to be reimbursed to Medicare and will issue a formal recovery demand letter advising the debtor (Medicare beneficiary, claimant or insurer) of the amount of money owed to the Medicare program. Interest begins accruing from the date of the demand letter, but is only assessed if the

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[2] http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Non-Group-Health-Plan-Recovery.html

[3] Medicare may only take beneficiary-borne costs into account.

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debt is not repaid or otherwise resolved within the time period specified in the recovery demand letter. Interest is assessed on unpaid debts even if there is an appeal or waiver request. The only way to avoid the interest assessment is to repay the demanded amount within the specified time frame and, then, if the waiver/appeal is granted, the beneficiary will receive a refund.

The attorney/representative will receive a copy of the RAR letter and others from the BCRC as long as the attorney/representative has submitted a Consent to Release form. With that form on file, the attorney/representative will also be sent a copy of the Conditional Payment Letter (CPL) and Demand Letter. If the attorney/representative wants to enter into additional discussions with any of Medicare's entities, the beneficiary will need to submit a Proof of Representation document. If a potential third-party payer submits a Consent to Release form, executed by the beneficiary, they too will receive CPLs and the Demand Letter. It is in the best interest of both sides to have the most accurate information available regarding the amount owed to the BCRC.

2. Workers' Compensation Liens

Under O.C.G.A. § 34-9-11.1(b), after an employer has paid workers' compensation benefits to an injured employee, the employer or its workers' compensation insurer is granted a subrogation lien for the benefits paid against the employee's recovery from a third-party tortfeasor found liable to the employee for the injury. To assert the subrogation lien, O.C.G.A. § 34-9-11.1(b) allows the employer or its insurer to intervene in the suit brought by the employee against the third party. *Department of Admin. Servs. v. Brown*, 219 Ga. App. 27, 464 S.E.2d 7 (1995). But if the workers' compensation insurer or employer fails to intervene, then it lacks standing to appeal dismissal of the action. *Astin v. Callahan*, 222 Ga. App. 226, 474 S.E.2d 81 (1996).

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The lien is strictly limited to the amount of the workers' compensation disability benefits, death benefits, and medical expenses paid to the employee. The lien is recoverable only if the injured employee has been fully and completely compensated for all economic and noneconomic losses incurred as a result of the injury. In determining whether the employee has been fully and completely compensated, the court must take into consideration both the benefits received under the workers' compensation act and the amount of the recovery in the third-party claim. *Hartford Ins. Co. v. Fed. Express Corp*., 253 Ga. App. 520, 559 S.E.2d 530 (2002). The employer/insurer had the burden of proving the employee has been fully and completely compensated. *Paschall Truck Lines, Inc. v. Kirkland*, 287 Ga. App. 497, 651 S.E.2d 804 (2007) (granting partial summary judgment to employee extinguishing subrogation lien). *See also Austell HealthCare, Inc. v. Scott*, 308 Ga. App. 393, 707 S.E.2d 599 (2011); *Ga. Elec. Mbrshp. Corp. v. Garnto*, 266 Ga. App. 452, 597 S.E.2d 527 (2004); *City of Warner Robins v. Baker*, 255 Ga. App. 601, 565 S.E.2d 919 (2002). Georgia courts will apply Georgia's workers' compensation scheme (including the "made whole" doctrine) when the injury occurs in Georgia – even if the claimant is employed by a foreign corporation and the claimant receives workers' compensation benefits in another state. *Liberty Mutual Ins. Co. v. Roark*, 297 Ga. App. 612, 613-614, 677 S.E.2d 786 (2009).

Inserting language into a settlement release stating that the plaintiff "has not been fully and completely compensated" does not extinguish the workers' compensation carrier's lien. *SunTrust Bank v. Travelers Prop. Cas. Co*., 321 Ga. App. 538, 542, 740 S.E.2d 824 (2013) (holding that "it is solely for the trial court — not a jury, the employee, or third-party tortfeasors — to determine whether the insurer has met its burden of showing that the employee has been fully compensated for his or her injuries.").

3. Medical Provider Liens

a) Who has a lien?

"Any person, firm, hospital authority, or corporation operating a hospital, nursing home, or physician practice or providing traumatic burn care medical practice in [Georgia] shall have a lien for the reasonable charges . . . for care and treatment of an injured person. . . ." O.C.G.A. § 44-14-470(b). "Physician practice" was added to Georgia's medical lien statute July 1, 2004. A "physician practice" is defined as any medical practice that includes one or more physicians licensed to practice medicine in this state. O.C.G.A. § 44-14-470(a)(4).

b) What is the lien for?

The lien is "for the reasonable charges . . . for care and treatment of an injured person. . . ." O.C.G.A. § 44-14-470(b). Even where there is an agreement or contract to pay the charges, as observed by the Supreme Court, the door is open to challenge the lien. "[T]he general proposition that hospital charges are automatically 'reasonable' whenever the patient (or someone authorized to act on her behalf) has signed a contract agreeing to pay those charges is incorrect, because the contract price for goods and services does not necessarily equal their reasonable value." *Bowden v. The Medical Center, Inc.*, S14G1632, 2015 Ga. LEXIS 436 at 20 (Ga. June 15, 2015). "O.C.G.A. § 44-14-470(b) says that the hospital has a lien for the 'reasonable charges' for a patient's care, not a lien for 'whatever the patient agreed to pay.'" *Id.*

In *Bowden*, the patient against whom the hospital was seeking to enforce the lien sought discovery on the hospital's pricing agreements with various insurance plans and billing practices. The hospital objected to the discovery. The patient to file a motion to compel in which the patient argued that information concerning how much the hospital charged other patients, insured or not, for the same care during the same time period was relevant to the reasonableness of the

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charges the hospital sought through its lien. The trial court granted the motion to compel and the Court of Appeals reversed. The Supreme Court took up the case and reversed the Court of Appeals, deciding that the information sought was not irrelevant to determine the reasonableness of the hospital's charges. *Id.*

c) What/Who is the lien against?

The lien is against any and all causes of action accruing to the person to whom the care was furnished or to that person's legal representative on account of injuries giving rise to the causes of action and which necessitated the care. O.C.G.A. § 44-14-470(b). The statute was amended in 2002 to emphasize that the lien is only a lien against the cause of action and is not a lien against the injured person, the person's legal representative, or any other property or assets of such persons. *Constantine v. MCG Health, Inc.*, 275 Ga. App. 128, 130, 619 S.E.2d 718 (2005) (citing O.C.G.A. § 44-14-470(b) and Ga. L. 2002, p. 1429, § 1), *overruled in part*, *MCG Health, Inc. v. Kight*, 325 Ga. App. 349, 750 S.E.2d 813 (2013) (whole court). The lien shall not be evidence of the patient's failure to pay a debt. O.C.G.A. § 44-14-470(b). Medical liens do not apply to any moneys due under the Workers' Compensation Act. O.C.G.A. § 44-14-474.

The medical lien is subject to any attorney's lien. O.C.G.A. § 44-14-470(b). See also *Holland v. State Farm Mut. Auto. Ins. Co.*, 236 Ga. App. 832, 834, 513 S.E.2d 48 (1999) (reversing the trial court's finding that the attorney's lien was untimely asserted and did not take priority over the hospital and Medicaid liens); *Ramsey v. Sumner*, 211 Ga. App. 202, 438 S.E.2d 676 (1993) (attorney's lien takes priority over hospital lien). In *Thomas v. McClure*, the UM carrier paid its $15,000 policy limits into the registry of the court. Tanner Medical Center's lien was for $13,397.00 of medical treatment. The court awarded the hospital only $8,681.00 and

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awarded the plaintiff's attorney the remainder to cover his fees and expenses. *Thomas v. McClure*, 236 Ga. App. 622, 624, 513 S.E.2d 43 (1999).

d) When does the lien attach?

The lien attaches at the moment the patient begins receiving medical treatment. *Thomas v. McClure*, 236 Ga. App. at 624; *Macon-Bibb County Hosp. Authority v. National Union Fire Ins. Co*., 793 F.Supp. 321, 323 (M.D. Ga. 1992). "The statute sets out no conditions precedent such as filing requirements for obtaining a valid lien." *Id*. Thus, a medical provider's late filing to perfect the lien has no effect on the validity of the lien. *Id*.

e) How is the lien perfected?

A medical provider must satisfy two requirements before the lien is perfected. *Kennestone Hospital, Inc. v. The Travelers Home and Marine Ins. Co*., 330 Ga. App. 541, 541-42 (2015).

First, the medical provider must provide written notice to the patient and, to the best of the medical provider's knowledge, the person's firms, corporations, and their insurers claimed by the injured person to be liable for the damages arising from the injuries. O.C.G.A. § 44-14-471(a)(1). This notice has to be sent to <u>all</u> such persons and entities by first-class <u>and</u> certified mail or statutory overnight delivery, return receipt requested. *Id*. This notice must be sent at least 15 days before meeting the second requirement—the filing of a verified statement in the superior court. *Id*. "[T]he phrase 'best of' to describe the lienholder's knowledge imposes a requirement on the lienholder to exercise at least some degree of diligence in acquiring the information necessary to send the notice." *Kennestone*, 330 Ga. App. at 544 (finding the hospital did not exercise appropriate diligence in obtaining and using information necessary to send notice).

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Second, after the above notice is sent, the medical provider is required to file in the office of the clerk of the superior court of the county in which the hospital, nursing home, physician practice, or provider of traumatic burn care medical practice is located and in the county wherein the patient resides, if a resident of Georgia, a verified statement setting forth the name and address of the patient as it appears on the patient's records, the name and location of the medical provider and operator, the dates of admission and discharge of the patient and/or dates of treatment, and the amount claimed to be due. O.C.G.A. § 44-14-471(a)(2). If the statement is filed by a hospital, nursing home, or traumatic burn care provider, then the statement must be filed within 75 days of the patient's discharge. O.C.G.A. § 44-14-471(a)(2)(A). If the statement is filed by a physician practice, then the statement must be filed within 90 days after the person first sought treatment. O.C.G.A. § 44-14-471(a)(2)(B).

The failure to perfect the lien as required invalidates the lien, except as to any person, firm, or corporation liable for the damages who receives prior to the date of any release, covenant not to sue, or settlement, actual notice of a notice and filed statement, via hand delivery, certified mail, return receipt requested, or statutory overnight delivery with confirmation of receipt. O.C.G.A. § 44-14-471(b). Therefore, the failure to perfect the lien within the time period set forth in O.C.G.A. § 44-14-471(a) does not invalidate the lien when a liable party against whom the hospital sought to enforce the lien received actual notice of the lien prior to settlement. *Thomas v. McClure*, 236 Ga. App. at 624. [4] In *Thomas*, the lien was

[4] The court in *Macon-Bibb County Hosp. Authority v. National Union Fire Ins. Co*., addressed a similar issue, but involved the defendant's insurer. In that case, the court reached the conclusion strict compliance was not required where actual notice to the insurer was provided. 793 F.Supp.at 323. That case is questionable authority now given it was decided under the old version of the statute and the Georgia Court of Appeals' decision requiring strict compliance when a hospital sought to enforce a lien against the defendant's insurance company. *Kennestone*, 330 Ga. App. at 546.

perfected 3 days late by the hospital, but the party responsible for the patient's injuries received actual notice, by certified mail, of the liens before the case was resolved. The court concluded that the purpose of the filing requirement was notice, and because actual notice was accomplished the court held that timely perfection of the liens did not prevent enforcement. The court rejected the argument that strict compliance with the medical lien statute was required because at the time the decisions were rendered the medical lien statute lacked language requiring strict compliance, unlike the mechanics lien statute. The medical lien statute was subsequently amended in 2002 to codify a strict compliance requirement with an exception when a liable party receives actual notice. O.C.G.A. § 44-14-471(b).

The filing of the lien constitutes notice of the lien to those liable for the damages, whether or not they received written notice. O.C.G.A. § 44-14-471(b). The filing of the lien without providing the requisite notice, however, does not constitute notice to an insurer of the person, firm, or corporation liable for the damages. *Kennestone*, 330 Ga. App. at 546 (holding that actual notice to Travelers did not save Kennestone's improperly perfected lien).

f) The Superior Court Clerk's obligations.

The superior court clerk is required to file stamp the verified statement and maintain an indexed lien book with the name of the medical provider, the name of the patient, and the amount claimed. O.C.G.A. § 44-14-472. The verified statement shall be recorded in the name of the patient. *Id*. The regular filing fee for such a recording applies. *Id*.

An invaluable tool to search for medical liens is available through the Georgia Superior Court Clerks' Cooperative Authority ("GSCCCA"). The GSCCCA makes medical liens from most Georgia counties searchable on-line through its website. In order to use the service you

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must register and obtain a log in and password. There is a fee associated with the service, but it is nominal compared to having to make routine trips to many different court houses.

g) A medical lien can be enforced against the party responsible for the damages or that party's insurer through an action to foreclose on the lien.

"[T]he claimant or assignee of the lien may enforce the lien by an action against the person, firm, or corporation liable for the damages or such person, firm, or corporation's insurer." O.C.G.A. § 44-14-473(a). Practically speaking, the claimant should bring the action to foreclose on the lien against both the liable party and the liable party's insurer. A lien claimant, however, is not provided an independent right of action to determine liability for injuries sustained by a person or firm. O.C.G.A. § 44-14-476.

A claim against an uninsured motorist carrier is treated no differently than a claim against a tortfeasor covered by a liability insurance policy. The lien statute applies equally to claims against uninsured motorist carriers because the uninsured motorist claim accrues to the injured person as a result of the injuries arising out of an accident for which the injured person received treatment. *Thomas v. McClure*, 236 Ga. App. at 624.

h) A lien claimant can recover attorney's fees in an action to foreclose on the lien.

"If the claimant prevails in the action, the court may allow reasonable attorney's fees." O.C.G.A. § 44-14-473(a).

i) There is a one year limitations period on enforcing medical liens.

"The action shall be commenced against the person liable for the damages or such person's insurer within one year after the date the liability is finally determined by a settlement, by a release, by a covenant not to bring an action, or by the judgment of a court of competent jurisdiction." O.C.G.A. § 44-14-473(a). Jurists from both the Georgia Supreme Court and the

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Georgia Court of Appeals have criticized this statute as being unclear because the events triggering the one-year period are not clearly distinct and more than one of those events may occur in a single case. *Hosp. Auth. of Athens-Clarke County. v. Geico Gen. Ins. Co*., 294 Ga. 477, 479-480, 754 S.E.2d 358 (2014) (Nahmias, J., concurring) ("If the General Assembly wants O.C.G.A. § 44-14-473(a) to be clearly understood and correctly and fairly applied, the statute needs to be amended."); *Geico Gen. Ins. Co. v. Hosp. Auth. of Athens-Clarke County*, 319 Ga. App. 741, 328-329, 738 S.E.2d 325 (2o13) (Boggs, J., concurring specially) ("I write specially to express my concern that the language of O.C.G.A. § 44-14-473 has the potential for creating problems in the future in analyzing the statute, particularly in light of our court's existing body of law on the creation and legal effect of settlements and releases."). They have also expressed concern that there is no mechanism in the statute requiring any notice to the lienholder that the case is resolved. *Id*.

In *Hosp. Auth. of Athens-Clarke County. v. Geico Gen. Ins. Co*., a settlement of the underlying personal injury suit was reached and confirmed in writing on September 10, 2010 and the settlement agreement was executed on October 8, 2010. The hospital, whose lien was not satisfied, filed suit against Geico on October 6, 2011, two days before the one year anniversary of the signing of the settlement release. Geico moved for summary judgment at the trial court claiming that the one-year limitations period began to run from the time the settlement was reached on September 10, 2010. The trial court denied Geico's motion for summary judgment and the Court of Appeals reversed, holding that the one-year period began to run from the time the settlement was reached. The Supreme Court reversed the Court of Appeals holding that the limitations period began to run from the signing of the settlement release. *Hosp. Auth. of Athens-Clarke County. v. Geico Gen. Ins. Co*., 294 Ga. at 479.

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In a case in which Henry Medical Center rendered treatment to an automobile accident victim, the hospital argued that the settlement release did not "finally determine liability" in an unsuccessful attempt to circumvent the one year limitations period. *Integon Indemnity Corp. v. Henry Medical Center, Inc.*, 235 Ga. App. 97, 100, 508 S.E.2d 476 (1998). The hospital's first argument was that the release did not finally determine liability because the release contained language that the released parties expressly denied liability. *Id.* The court disagreed because the hospital's lien was on only the cause of action, liability in the tort action was avoided permanently by the settlement and release, and no further action against the tortfeasor was permitted. *Id.* The hospital's second argument was that the release did not finally determine liability because it was a limited release made pursuant to O.C.G.A. § 33-24-41.1. *Id.* The court again disagreed with the hospital because a limited release is only limited in that the release of one liable insurer does not operate to release other carriers providing coverage or other tortfeasors and their carriers. *Id.*

A Medicaid lien can likewise be waived if not brought within the requisite limitations period. *Department of Medical Assistance v. Hallman*, 203 Ga. App. 615, 417 S.E.2d 218 (1992).

j) What is the effect of a settlement release on a medical lien?

"No release of the cause or causes of action or of any judgment thereon or any covenant not to bring an action thereon shall be valid or effectual against the lien created by O.C.G.A. § 44-14-470 unless the holder thereof shall join therein or execute a release of the lien." O.C.G.A. § 44-14-473(a). "No release or covenant not to bring an action which is made before or after the patient was discharged from the [facility] or, with respect to a physician practice, which is made after the patient first sought medical treatment from the physician practice for the injuries shall

be effective against the lien perfected in accordance with Code Section 44-14-471, if such lien is perfected prior to the date of the . . . settlement unless consented to by the lien claimant; provided, however, that any [party consummating the settlement] first procures from the injured party an affidavit . . . shall not be bound or otherwise affected by the lien except as provided in subsection (c) of this Code section, regardless of when the settlement . . . was consummated." O.C.G.A. § 44-14-473(b).

No settlement or release entered into or executed prior to treatment by the lien claimant is affected by or subject to the medical lien statute. O.C.G.A. § 44-14-475.

Georgia's complete compensation rule does not apply to medical liens. *Holland v. State Farm Mut. Auto. Ins. Co*., 236 Ga. App. 832, 834, 513 S.E.2d 48 (1999). In *Holland*, an interpleader action filed by State Farm to determine priority of the lien claims, the injured party argued that the hospital and Medicaid's lien claims should not be satisfied until he was made whole. *Id*. The court rejected this argument holding that the complete compensation rule only applies to the subrogation rights of an insurance carrier who has made payments on behalf of the injured party and then seeks recovery of those payments. *Id*.

k) The "Lien Affidavit"

An affidavit meeting the requirements of O.C.G.A. § 44-14-473(c) will protect "any person, firm, or corporation which consummates a settlement, release, or covenant not to bring an action" with the injured party from enforcement of the lien by the medical provider, so long as no lien in the name of the injured party is on file with the clerk of the superior court of the county wherein the injured party resides. O.C.G.A. § 44-14-473(b) and (c). The affidavit shall affirm: (1) that all hospital, nursing home, physician practice, or provider of traumatic burn care medical practice bills incurred for treatment for injuries for which a settlement is made have

been fully paid; and (2) the county of residence of such affiant, if a resident of Georgia. *Id*. Providing a false affidavit under this Code section constitutes the offense of false swearing. O.C.G.A. § 44-14-477.

l) Medical liens do not qualify as payment of other claims or otherwise under the UM statute.

Medical liens do not qualify as "payment of other claims or otherwise" under O.C.G.A. §33-7-11(b)(1)(D)(ii). Therefore, medical liens do not reduce a tortfeasor's available liability coverage to increase the coverage provided by an injured party's UM carrier. *State Farm Mut. Auto. Ins. Co. v. Adams*, 288 Ga. 315, 702 S.E.2d 898 (2010); *American Intern. South Ins. Co. v. Floyd*, 288 Ga. 322, 704 S.E.2d 755 (2010).

m) The interaction between a medical lien and health insurance.

When a hospital or other medical provider enters into a managed care contract, a question arises as to the effect of that agreement on any independent rights the provider may have against tort settlements. For example, in *Parnell v. Adventist Health System/West*, 35 Cal.4th 595, 109 P.3d 69, 26 Cal.Rptr.3d 569 (2005), the court held that the statutory hospital lien required the existence of an underlying debt owed by the patient to the hospital. In effect, the managed care agreement extinguished the debt, so that no lien could attach. The court viewed this result as consistent with the "vast majority of courts from our sister states" that had construed analogous statutes. See, e.g., *Constantine v. MCG Health, Inc.*, 275 Ga. App. 128 (2005), *overruled in part*, *MCG Health, Inc. v. Kight*, 325 Ga. App. 349, 750 S.E.2d 813 (2013) (whole court) ("*Kight I*"). However, *Constantine* has been implicitly overruled, in part, and will no longer be followed to the extent it held that the absence of a debt to a hospital as a result of a contract with a health

insurer precluded a hospital lien. *Kight I*, *affirmed*, *in part*, *Kight v. MCG Health, Inc*., 296 Ga. 687, 769 S.E.2d 923 (2015) ("*Kight II*").

In *Kight I*, the court found that the hospital lien was not voided by the hospital's acceptance of payments pursuant to the managed care contract. The Court reasoned that under the collateral source rule the patient could seek full recovery of reasonable and necessary hospital charges undiminished by insurance payments or 'write-offs' under the hospital's managed care contract. Therefore, the hospital was entitled to assert a lien under O.C.G.A. § 44-14-470(b) for the unpaid portion of those billed charges.

The Supreme Court granted certiorari and affirmed the Court of Appeals' decision, but only on a narrow basis, stating that much of the Court of Appeals' opinion was dicta. *Kight II*. The court found that the determinative factor was that the hospital was owed money on the date the lien was filed and, therefore, the argument that there was no debt on which to base a lien failed. The court also found that the hospital's contract with the patient's health insurer explicitly reserved the hospital's right to collect deductibles and co-pays directly from the patient, irrespective of the agreement to hold the patient responsible only for a discounted treatment price. *Kight II*, 296 Ga. at 689.

Prior to *Kight I* and *Kight II*, the Georgia Supreme Court held a hospital cannot enforce a lien against the tortfeasor's insurer if the patient is a beneficiary of TRICARE, a federal health insurance program for military personnel. *MCG Health, Inc. v. Owners Ins. Co*., 288 Ga. 782, 707 S.E.2d 349 (2011). The Supreme Court "found that the 'any recourse' provision [in the managed care contract] prohibited the hospital lien because any attempt to collect the lien for those amounts against tort settlement proceeds (which had already been paid out to the injured insured) would cause the insured an 'immediate financial loss' and defeat the purpose of the

contract 'for Tricare beneficiaries to have their healthcare costs paid in full at the negotiated rates without fear of further recourse.'" *Id*. at 786.

While the language in *Kight I* clearly overturns the prior case law, there have been no cases interpreting whether a contract provision prohibiting a hospital from 'any recourse' would void a hospital lien if the patient is not a beneficiary of a federal health insurance program for military personnel. *See MCG Health, Inc. v. Perry*, 326 Ga. App. 823, 838, 755 S.E.2d 341 (2014) (declining class certification in part because, “Another question to be resolved under the various contracts is whether there is contractual language (absent in *Kight*) that would prevent such a recovery by the hospital, such as a ‘no recourse’ waiver.”). It appears Plaintiff's counsel, as a part of diligently representing her client, bears the burden to obtain, analyze, and determine what type of recourse provision their client's managed care contract contains.

n) Medicaid liens.

Medicaid liens are very similar to medical liens. “The Department of Community Health shall have a lien for the charges for medical care and treatment provided a medical assistance recipient upon any moneys or other property accruing to the recipient to whom such care was furnished or to his legal representatives as a result of sickness, injury, disease, disability, or death, due to the liability of a third party, which necessitated the medical care.” O.C.G.A. § 49-4-149(a). In order to perfect and enforce a lien the Department of Community Health (“DCH”) has to follow similar procedures as the medical providers listed in O.C.G.A. § 44-14-470 (a). O.C.G.A. § 49-4-149(b). DCH is required to follow O.C.G.A. § 44-14-470 through 473, except that DCH has one year from the date the last item of medical care was furnished to file its verified lien statement and the statement must be filed in the county of residence of the recipient and in Fulton County. *Id*.

4. Child Support Recovery Liens

A child support obligation which is unpaid in whole or in part shall, as of the date on which it was due, be a lien. O.C.G.A. § 19-11-18(b)(1). The Agency can file or record notice of lien in any office or agency responsible for filing or recording liens. The lien expires upon payment in full of the unpaid child support, release of the lien, or after six years (but it can be renewed). O.C.G.A. § 19-11-18(b)(5). A person in possession of property upon which a lien has priority … which has been perfected shall, upon demand, surrender the property…. O.C.G.A. § 19-11-18(c)(1). Upon demand by the Agency, a person who fails or refuses to surrender property subject to levy… shall be liable in his or her own person and estate to the state in a sum equal to the value of the property not so surrendered but not exceeding the amount of the lien, together with costs and interest…. O.C.G.A. § 19-11-18(c)(3). Any person who upon demand by the Agency surrenders the property, discharges the obligation to the Agency, or pays a liability to the obligor under this subsection, shall be discharged from any obligation or liability to the obligor arising from the surrender payment. O.C.G.A. § 19-11-18(c)(4).

5. Health Insurance Liens

Health insurance liens or reimbursement claims are generally governed by the Employee Retirement Income Security Act of 1974 ("ERISA")[5] or state law principles of reimbursement.[6] As an initial step in every personal injury case, the practitioner should determine whether or not a plaintiff's health plan is subject to ERISA. This is because most, if not all ERISA plans now contain language obligating beneficiaries to reimburse the plan should the beneficiary recover damages from a third-party tortfeasor. On the other hand state law principles of reimbursement apply to health insurance reimbursement claims with the exception of Medicaid, Medicare, and

[5] 29 U.S.C. 1001 et seq.
[6] O.C.G.A. § 33-24-56.1.

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any health insurance plans preempted by ERISA. O.C.G.A. § 33-24-56.1 (providing that benefit providers, including employee benefit plans, may require reimbursement of medical expenses paid on behalf of an injured party in the event of a recovery for that personal injury from a third party). Under the state law principles of reimbursement, defenses such as the make-whole doctrine and common fund doctrine are available. These defenses are usually not available with ERISA plans.[7]

It can be difficult to determine whether or not a health plan is an ERISA plan.[8] Nearly all private employee health plans are ERISA plans, but not all are subject to the ERISA rules. Generally, an employer plan is subject to ERISA when it is a self-funded and it contains required language for reimbursement.

An employer plan is self-funded when the plan pays out benefits from a pool of money collected from the plan's own funds, from employee contributions, or both. A plan is not self-funded when it is fully-insured and benefits are paid out by group health insurance. You can find information on a plan's funding arrangement by looking at its Summary Plan Description ("SPD") and its Form 5500. An ERISA plan's SPD is required to disclose the funding arrangement of the plan. 29 U.S.C. § 1022(b). Do not rely on the SPD alone as they have been known to be inaccurate or incomplete at times. The Department of Labor's Form 5500 is an annual filing that is required for employers with at least 100 employees. The plans funding

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[7] *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537, 185 L.Ed.2d 654 (2013) (holding that "Neither general principles of unjust enrichment nor specific doctrines reflecting those principles—such as the double-recovery or common-fund rules—can override the applicable contract."); *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1236 (2010) (the make-whole doctrine does not apply when an ERISA plan contains specific language precluding it).

[8] Because of the complexities and constant changes in this area of the law, this article can only serve as a primer on ERISA and health insurance reimbursement claims. Before wading into this area of the law, a practitioner should review the current state of the law in evaluating a plan's claim to reimbursement.

arrangement is required to be reported on the Form 5500. This form can be located on-line at FreeERISA.com or by requesting a copy of the form from the plan administrator. 29 U.S.C. § 1024(b)(4).

A health-plan administrator may enforce a reimbursement provision by filing suit under § 502(a)(3) of ERISA. *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U. S. 356, 126 S. Ct. 1869, 164 L. Ed. 2d 612 (2006). That section authorizes a civil action "to obtain . . . appropriate equitable relief . . . to enforce . . . the terms of the plan." *Id*. This type claim is the modern-day equivalent of an action in equity to enforce a contract-based lien or an "equitable lien by agreement." *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537, 1545, 185 L.Ed.2d 654 (2013).

In *Sereboff* v. *Mid Atlantic Medical Services*, a health-plan administrator brought suit under §502(a)(3). Mid Atlantic had paid medical expenses for the Sereboffs after they were injured in a car crash. When they settled a tort suit against the other driver, Mid Atlantic claimed a share of the proceeds, invoking the plan's reimbursement clause. The Supreme Court held that that Mid Atlantic's action sought "equitable relief," as §502(a)(3) requires. Mid Atlantic claimed a portion of the Sereboff's settlement which was found to be "specifically identifiable funds" within the Sereboffs' control.

Recently the U.S. Supreme Court granted certiorari in the appeal of an 11th Circuit decision holding that an ERISA plan was authorized to recover money from a plan beneficiary even though the plan beneficiary had already spent most of his personal injury settlement. *Bd. Of Trs. Of the Nat'l Elevator Indus. Health Benefit Plan v. Montanile*, 593 Fed. Appx. 903 (11th Cir. 2014). In *Montanile*, the 11th Circuit reached the decision that even though most of the settlement had "dissipated," the ERISA plan could maintain an equitable lien action against the plan beneficiary. *Id*. at 907. The court relied on its prior decision in *AirTran Airways, Inc. v.*

*Elem*, which held that "the settlement funds were 'specifically identifiable,' and a plan participant's dissipation of the funds thus 'could not destroy the lien that attached before' the dissipation." 767 F.3d 1192 (11th Cir. 2014) (emphasis original). The *AirTran* decision has an application for certiorari pending. A decision by the U.S. Supreme Court should resolve a split among eight circuits over this issue, with two circuits holding that a plan cannot enforce an equitable lien when the plan participant is no longer in possession of the settlement funds.