

MED PAY DISBURSEMENTS

By
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GENERAL OVERVIEW

I. The policy

A. Coverage

This manuscript will not go into great detail on how to find coverage. There is a terrific manuscript by Joan Mitchell on Med Pay issues that you can consult for more information on finding coverage. The manuscript is in the Masters of Insurance Seminar (2002). However we need to discuss what part of the medicals will be covered in order to know how best to disburse your med pay proceeds.

We have to first look at how the policy reads in the insuring agreement. The policy states:

“We will pay reasonable expenses incurred for necessary medical and funeral services because of bodily injury caused by an accident and sustained by an insured.

We will pay only those expenses incurred for services rendered within 3 years from the date of the accident.

B. What is reasonable?

In order to first discuss what is reasonable, we need to first look at what the policy specifically states about what is not reasonable and what is reasonable:

First the policy states reasonable medical expenses **do not** include expenses:

- 1) For treatment, services, products or procedures that are:
 - a. Experimental in nature, for research or not primarily designed to serve a medical purpose; or
 - b. Not commonly and customarily recognized throughout the medical profession and within the United States as appropriate for the treatment of the bodily injury; or
- 2) Incurred for
 - a. The use of thermography or other related procedures of a similar nature, or;
 - b. The use of acupuncture or other related procedures of a similar nature; or
 - c. The purchase of rental or equipment not primarily designed to serve a medical purpose

Secondly, expenses are reasonable only if they are consistent with the usual fees charged by the majority of similar medical providers in the geographical area in which the expenses were incurred for the specific medical services.

We have all seen the explanation of benefits of where the insurance carriers cut the providers bills saying they charged too much. The reasonable and necessary language is where you will have most of your disputes with the insurance company for payment.

C. What is Necessary?

Again, you must first look at the policy. Services are only necessary if the services are rendered by a licensed medical provider within the scope of the provider's practice and license and are essential in achieving maximum medical improvement for the bodily injury sustained in the accident.

The insurance company can make or obtain a utilization to review what is reasonable and necessary for the bodily injury sustained. When the insurance company makes a review they typically use an outside vendor to determine what is reasonable and customary. It is a medical bill review system. It may be by computer or by another medical provider.

D. What do we say is reasonable and necessary?

Under North Carolina law, there is a presumption of reasonableness. N.C. Gen. Stat. §8-58.1 (1986). The insurance company can rebut this presumption for reasonableness of the charges and the necessity of the charges. See Jacobsen v. McMillan, 124 N.C. App. 128, 476 S.E.2d 368 (1996).

The insurance company will have to put their utilization reviews to the test and challenge the bills. If they fail to provide evidence to rebut the reasonableness of the charges, then the reasonable is conclusively established. McCurry v. Painter, 146 N.C. App. 547, 553 S.E.2d 698 (2001). When there is a dispute over reasonable and necessary charges and you as the attorney have to file suit, the insurance company will likely be required to put the computer system or their medical provider on the stand. Typically insurance companies will try to keep their procedures out of the court rooms if at all possible.

E. What is "Incurred"?

Insurance companies now want to deny med pay coverage indicating it is not incurred since the insured did not pay for it. They want to interpret incurred to mean actually owed. Unfortunately most court cases dealing with incurred expenses apply to third party cases. However, incurred should mean the same thing across the board.

Remember insurance contracts expanding coverage are construed liberally and exclusions are construed narrowly. State Capital Ins. Co. v. Nationwide Mutual Ins. Co., 78 N.C. App. 542, 337 S.E.2d 866 (1985). If the insurance company wanted to only pay what was owed, then it could use that language.

Liability or debt is sufficient to show that expenses have been incurred. Williams v. Charles Stores Co. Inc., 209 N.C. 591, 184 S.E.2d 496 (1936). The Court of Appeals allowed expenses that had been written off by Medicare to be included in the expenses submitted to jury. Badgett v. Davis 104 N.C. App. 760, 411 S.E.2d 200 (1991). The mere fact the plaintiff has insurance should not preclude the plaintiff from collecting its full measures of damages from the defendant. In Young v. Baltimore and O.R Co., 266 N.C. 458, 146 S.E.2d 441 (1996). As this may apply in third party cases, the insured has a paid a premium for this additional coverage and the analysis for incurred expenses should be the same.

However, future expenses are not included as incurred. See Atkins v. Great American insurance Co., 15 N.C. App. 79, 189 S.E.2d 501 (1972).

F. When and what to submit?

When an attorney is handling med pay for a client, he/she can submit it any time they have bills. As a practical matter, I think it is best to get the amount of med pay verified and get records/bills in that amount. Then simply make one submission for payment and go through one disbursement. Since the adjusters are using utilization reviews, it is hard to go back and check which bills were already inputted to which ones have to be inputted into their system and the process can be delayed. A one time submission makes your disbursement easier. However, as always, you must talk with your client and determine what is his/her best interest.

When submitting the bills, the med pay adjuster will not process the bills without ICD-9 or CPT codes. ICD-9 codes are the diagnostic codes. You will see codes like 847.0, 847.1, 847.2, etc. These codes indicate neck strain, thoracic strain and lumbar strain. There is a website at <http://www.medical-coding.net/data/icd9/icd-9-cm.htm> that you can search the ICD9 codes to be sure the diagnosis is related to your accident.

The CPT codes are the 99289, 99283, 72040, etc that you see on bills. These CPT codes help determine what is typically charged for the type of services rendered. The 99283 is usually a physician's code and depending on the level of examination will determine the costs. There are books you can buy to determine what code should match what procedure the doctor actually did. You can also access information about CPT codes on line at <http://www.amaassn.org/ama/pub/category/3113.htm>.

It is important to review your bills and become familiar with your CPT and ICD9 codes. There have been providers and attorneys who have been investigated for inputting a CPT code that does not match the records presented. So be aware of what you are submitting.

Sometimes you can submit just the bills. Other times you will have to submit the records. I only submit that which I need to reach the med pay limits. I do not offer more than what is needed unless specifically asked. Most insurance companies are not disputing much of the initial treatment by the ambulance or at the emergency room where they have been transported. The insurance companies have come to understand that your client has no choice to where he/she may be taken when they are hurt at the scene.

G. Can you submit a hold harmless agreement?

NO! RPC 228 states a lawyer for a personal injury victim may not execute an agreement to indemnify the tortfeasor's liability insurance carrier against the unpaid liens of medical providers. RPC 228 is attached to the manuscript

More and more adjusters are requesting this and you simply cannot do this.

I do, however, request the check be sent to my office and be made payable to my client and my firm. I will also let them know I will disburse any proceeds in accordance with any applicable federal and North Carolina state laws. This statement will usually satisfy the adjuster and payment will be issued.

II. MED PAY Payments

A. Payment in full?

If the payment is received for the full amount of med pay coverage, you can proceed to disburse. Not a problem, you have done all things right to this point.

B. Payment is reduced?

If the payment is reduced due to unreasonable charges, I request an explanation of benefits or a written reason why. Many times, they have not inputted the information correctly into their review system for the claim to be processed correctly. Most insurance companies are now sending an explanation of benefits, much like you will see from a health insurance company. In addition, ask what geographical area the reduction was based. Then request information on providers who charge the lower amount and call the provider and find out if they actually charge this lesser amount. A written letter from providers in your area stating they are charging the same amount or even more can get the insurance company to increase their payment.

If the bill is reduced because of a policy exclusion, you must check the exclusions in the policy. If the bill is reduced because the treatment was not necessary, get a written explanation for the basis of their decision. You could also contact your client's doctor to get a letter explaining the necessity to contradict the reduction.

If all else fails, FILE SUIT or request arbitration. Typically whenever I have filed suit, I get a call from the adjuster and I get the rest of the med pay money along with my filing and service fees.

In the lawsuit, I claim the damages that I have not received from the med pay adjuster. If the med pay coverage is \$2,000.00 and we have received \$1,500.00, my claim for damages is \$500.00. I document all that I have done in trying to get the med pay money with continued refusal and I put that in the complaint. I claim bad faith since this is a first party coverage in an attempt to recover punitive damages or treble damages under the Unfair Deceptive Trade Act. In order to recover punitive damages for the tort of an insurance company's bad faith refusal to settle, the plaintiff must prove (1) a refusal to pay after recognition of a valid claim, (2) bad faith, and (3) aggravating or outrageous conduct. Lovell v. Nationwide Mutual ins. Co., 108 N.C. App. 416; 424 S.E.2d 181 (1993). The more times you can indicate you have tried to get this resolved, the better change you have to make the insurance company sweat.

I've also prepared the complaint and sent a letter requesting the balance of the med pay coverage or we will file within a certain # of days. Many times I've been able to get the rest of the med pay coverage paid almost immediately. When I was an adjuster, whenever a med pay complaint came in our defense attorneys didn't usually feel it was worth it to fight it for \$1000 or \$2000. This is more difficult if you have high med pay limits like \$10,000.00 or \$100,000.00 worth of coverage. Then the insurance company may feel the cost does not outweigh the benefit of defending the case

The arbitration clause is relatively new in the med pay portion of the policy. Unlike the underinsured motorist portion of the auto policy, it allows for either the insured or the insurer to request arbitration. Although the validity of the arbitration clause has not been held valid yet, "North Carolina has a strong public policy favoring the settlement of disputes by arbitration. Our strong public policy requires that the courts resolve any doubts concerning the scope of arbitrable issues in favor of arbitration." Johnston County v. R. N. Rouse & Co., 331 N.C. 88, 91, 414 S.E.2d 30, 32 (1992). "The party seeking arbitration must show that the parties mutually agreed to arbitrate their disputes." Routh v. Snap-On Tools Corp., 108 N.C. App. 268, 271-72, 423 S.E.2d 791, 794 (1992); see Thompson v. Norfolk S. Ry. Co., 140 N.C. App. 115, 120, 535 S.E.2d 397, 400 (2000). It appears the courts indicate that an agreement to

arbitrate, if contained in a contract covering other topics, must be independently negotiated. Blow v. Shaughnessy, 68 N.C.App. 1, 16, 313 S.E.2d 868, 876-877, *disc. review denied*, 311 N.C. 751, 321 S.E.2d 127 (1984). "This apparent requirement for independent negotiation underscores the importance of an arbitration provision and "militates against its inclusion in contracts of adhesion." *Id.* at 16, 313 S.E.2d at 877.

I think the language in the Blow cases gives us a valid argument to avoid arbitration that is demanded by the insurer.

C. What if the check is issued to someone else?

The checks are usually written to the attorney and the client. You can then proceed to disburse in accordance with the law.

If the check is issued to attorney, client and a medical provider, you either have to get all parties to sign and send the check to the medical provider or send the check back to the adjuster. In order to get the check reissued you will have to do one of the following:

- 1) let the adjuster know you will disburse in accordance with the law (not a hold harmless agreement)
- 2) Get the provider to accept less and agree to this in writing so the adjuster can send a check issued to the provider, the attorney and the client, which you can then send to the provider as payment on the account.
- 3) Wait until your liability case settles and try to handle it all at once to get the provider paid through the med pay check or show the med pay adjuster the provider has been paid in full and nothing is owed to the provider.

If the check is issued to your client and you have made no indication to the insurance company that you will disburse the med pay proceeds in accordance with the law, you can give the check to your client to proceed. However, I have seen insurance companies go to the client to get payment back if there was a valid assignment of benefits that was not paid. Advise your client accordingly.

III. MED PAY DISBURSEMENT

A. Attorney fees- can you take an attorney fee?

There has been controversy about whether you can take a fee on med pay settlements. RPC 35 indicates a lawyer generally may not charge a contingent fee to collect "med-pay." This prohibition is because generally there is no elevated risk to handling med pay claims. Typically, we submit the bills and get them paid.

However, it is not unethical to charge a reasonable fee. Where the med pay is disputed, I read the opinion as you can enter into a contract on contingency fees as long as the fee is reasonable.

The benefit of an attorney handling the med pay is the client may be able to get some of the proceeds versus the adjuster sending it all to the chiropractor or the hospital. In addition, when an attorney is involved I think the med pay is paid quicker and with fewer reductions based on reasonable and necessary expenses.

The one issue where I question what fee you can take is when the med pay is part of the total settlement. For instances when you have an uninsured motorist claim that has an offset for med pay coverage so the amount of med pay coverage is part of the claim, can you take your contingent fee? If you have a med pay contract for handling med pay on a flat fee, you should take the flat fee for that portion. If you do not, I think this opinion indicates you cannot take a fee out of the med pay portion of the settlement if the collection of the med pay would not have been disputed. You may want to check with the State Bar.

RPC 174 does not allow for sliding scales of attorney fees.

Both RPC's are attached to the manuscript.

B. Military treatment liens?

Tricare considers medpay a primary insurance coverage and will not pay until med pay benefits are exhausted. If you want your client to have Tricare pay any of his/her bills, then you will need to disburse your med pay money to Tricare

C. Medicaid

If your client has a contractual right for benefits, N.C. Gen Stat. §108A-59 allows Medicaid to collect for reimbursement. Since med pay payments are based on a contractual right, Medicaid is entitled to be reimbursed fully from any medpay proceeds. If your Medicaid lien exceeds your med pay coverage, Medicaid is entitled to 100% of the med pay proceeds.

D. Medicare

Medicare also considers med pay as primary insurance coverage and Medicare as secondary. See 42 USC 1395y(b)(2)(A). Medicare will be entitled to that portion of med pay at 100%. Once your liability case settles and you have your conditional payment list from Medicare to approve, Medicare requests, in addition to the third party settlement information, what were the med pay benefits available to your client.

As Medicare reduces its liens for attorney fees and costs according to a formula they only determine the reduction on the amount of the payments after med pay benefits have been subtracted out of the rest of the lien. For instance let's say the final payments from Medicare totaled \$1,250.00. If you have no med pay coverage, Medicare may require you to pay back \$800.00 after considering attorney fees and costs. However, if you have conditional payments of \$1,250.00 and \$1,000.00 worth of med pay received, then Medicare will consider only \$250 to figure the reduction for attorney fees and costs. Once Medicare considers the reduction on only the \$250.00, the reduced amount may be \$150 based on your settlement. You would then owe Medicare \$1,150.00 for its total lien.

E. Workers' Compensation

First, there is an exclusion of med pay coverage for bodily injury resulting from the maintenance or use of any auto not owned by, or furnished for the regular use of, you or any family member, while that insured is employed or otherwise engaged in any business not described in exclusion 8 (see policy attached). This exclusion does not apply to you or any family member or if the bodily injury results from the operation of a private passenger auto or trailer by you.

There is also a non-duplication clause in the med pay contract. It states: "No person for whom medical expenses are payable under this coverage shall be paid more than once for the same medical expenses under this or similar vehicle insurance law, including any no fault benefits required by law."

These two provisions will typically be where a med pay adjuster will indicate there is no coverage for med pay when your client is eligible for workers' compensation. .

However, the first exclusion is very narrow and will be applied less frequently. The non-duplication clause will be the larger issue. The non-duplication clause indicates one cannot recover under similar vehicle insurance, including any no fault benefits. I construe this language to define similar vehicle insurance like PIP coverage. Most cases that deal with this clause have to do with stacking of med pay coverage. Again I look at these policies that if the insurance company wanted to exclude something they would say so. They have the power to do so, not my client, not their insured. It is a contract of adhesion and my client is stuck with it and has no bargaining power at all.

The worker's compensation statute N.C. Gen Stat. §97-10.2 that allows a lien for recovery is referenced to third party settlements only. Med pay is a first party coverage and since workers' compensation lien is created by statute, the statute would dictate if you have to repay workers' compensation benefits. The statutes do not indicate that med pay proceeds would be part of the amount reimbursable to the workers' compensation carrier. Again these issues may be affected

differently if it is a UM or UIM claim and the med pay may be a portion of that claim and in essence a derivative third party claim

F. N.C. Gen. Stat. § 44-49 and §44-50

N.C. Gen. Stat. §44-49 is attached but has the following language:

there is hereby created a lien upon any sums recovered as damages for personal injury in any civil action in this State.

In order to obtain a lien you have to receive the records/bills provide free of charge with written notice of the lien to the attorney.

From Smith v. State Farm Mut. Auto Ins., 358 N.C. 725, 599 S.E.2d 905 (2004), it appears that the court would agree that an assignment of benefits can act as a lien. I'd also encourage reviewing North Carolina Baptist Hospital, Inc. v. Mitchell, 323 N.C. 528, 374 S.E.2d 844 (1988) and Charlotte Mecklenburg Hosp. Auth. v. First of Ga. Ins. Co., 340 NC 88, 455 S.E.2d 655 (1995) when determining if the provider has a valid lien.

In addition, Doug Maynard has provided a manuscript in this seminar about valid liens under the N.C. Gen. Stat. §44-49 and §44-50.

N.C. Gen. Stat §44-50 is attached to the manuscript and has the following relevant language:

A lien as provided under G.S. 44-49 shall also attach upon all funds paid to any person in compensation for or settlement of the injuries, whether in litigation or otherwise.

Whether med pay is subject to disbursement under N.C. Gen. Stat. §44-50 has not been decided by our courts. However, N.C. Gen. Stat §44-50 indicates a lien attaches to all funds paid. I read all funds paid to include med pay. Now the dispute is N.C. Gen. Stat. §44-49 which states a lien is created upon any sums recovered as damages. Black's Law Dictionary defines many different types of damages. However, one definition states "a pecuniary compensation or indemnity, which may be recovered in the courts by any person who has suffered loss, detriment or injury, whether to his person, property or rights through the unlawful act or omission or negligence of another." Blacks Law Dictionary 389 (6th ed. 1990). Well, our client's request for med pay is for compensation for injury through the negligent acts of a third party. I think the courts could construe med pay coverage as damages. Then when you read §44-49 in conjunction with § 44-50 that states the lien attaches to any funds paid to any person for compensation for injuries, med pay is a form of compensation. I disburse my med pay claims in accordance with the lien statutes.

G. ERISA plans

If you have decided your client is covered by a qualifying ERISA plan, you must review the policy language to determine whether you must reimburse the plan and to what extent. Not all plans have language indicating they have a right to reimbursement from med pay coverage.

IV. General Duties of the Insured

A. Policy

The policy requires some general duties of an insured when submitting a claim. You can consult the policy but the few that affect med pay are:

- 1) Cooperate with us in the investigation, settlement or defense of any claim or suit.
- 2) Submit as often as we reasonably require to physical exams by physicians we select and to examinations under oath
- 3) Authorize us to obtain medical reports and other pertinent records
- 4) Submit a proof of loss when required by us.

B. Does my client have to submit to a recorded statement?

Yes. It is to help investigate for settlement and it is better than an examination under oath. However, if your client has a UIM claim that will be in conjunction with the med pay case, I sometimes try to hold off on the statement or allow the statement to be only on the facts of the accident as the client is deciding what coverages he may or may not want to use. Sometimes I will let them know my client is deciding what coverages they may or may not use and we will set a later time for the statement. Then I submit the medical bills and records that show the injuries and tell them if they still need a statement from my client after reviewing these records to let me know and we will schedule a statement.

Eventually though, the insurance company is entitled to the information and you do not want to void coverage for your client. See *Fineburg v. State Farm* 113 N.C. App 545, 438 S.E.2d 754 (1994) and *Baker v. Independent Fire Ins.*, 103 N.C. App. 521, 405 S.E.2d 778 (1991).

C. Do you have to provide a medical authorization to the adjuster?

Yes. Again it is a duty of the insured seeking coverage. Again I try to give them the records with the signed authorization so hopefully they will proceed to issue the med pay coverage check and then do nothing else. I also try to

wait and send it all in if it is a UIM claim for the same reason. I do not want an adjuster to be prejudiced by something before I can have all of my information in order to make the best possible claim for my client under all coverages available.

IV. Offsets

A. Liability

Muscatell v. Muscatell and Ysteboe 145 NC App 1998, 550 S.E.2d 836 (2001) held that med pay was a collateral source and the defendant should not benefit from the credit of the med pay coverage.

When doing your disbursements when med pay may be lumped into the liability settlement, you need to determine how you will take a fee on that med pay portion of the case.

B. UM and UIM

Under Baxley vs. Nationwide Ins. Co., 104 N.C. App. 419, 410 S.E.2d 12; (1991) there was no offset for payments made under the med pay coverage for payment to be made under the UM coverage because the policy did not indicate otherwise.

However, the insurance policy now allows for the non-duplication of payments under the UM/UIM for any payments made under the med pay portion of the policy. Espino v. Allstate Indemnity Co., 159 NC App 686, 583 S.E.2d 376 (2003) allowed the offset pursuant to the policy language.

Again for disbursement purposes you must consult the ethical rules for the amount of fee you can take on the med pay when it is included with our UM/UIM settlement.

V. DISBURSEMENTS IN GENERAL

You should always be sure your client understands the disbursement and signs off on any disbursements.

See RPC 125

See 2001 Formal Ethics Opinion 2001

These are only a few opinions and rules to review before doing disbursement. They are in no way exhaustive of all potential applicable rules. The ones listed are attached to the manuscript