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Medical and P.I. Liens in North Carolina

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Liens on Personal Injury Settlements

(With special thanks to John T. O'Neal of the O'Neal Law Office [www.oneallawoffice.com] for updating and editing this manuscript. John thanks Arthur J. Donaldson, Esq., for allowing him to incorporate his teachings and portions of various manuscripts on liens, distribution of personal injury settlements, handling medical liens, and claims for reimbursement and subrogation.)

Liens, claims, demands, reimbursement, subrogation… these are some of the proverbial hands reaching into your client's personal injury recovery proceeds. As you have apparently done the work needed to secure the money, you need not be intimidated by these buzzwords. Instead, use this short manuscript as an introductory means of understanding and prioritizing these claims so as to maximize your client's recovery. Be sure to consult statutes, case law, and other more detailed sources for additional questions or issues not addressed in this manuscript.

A lien is a charge or security or encumbrance upon property.[1] It is the right to possess and retain something until some charge upon it is paid or removed. It is the right to have a demand satisfied out of the property of another. For personal injury attorneys, liens attach to the trust account in which settlement proceeds are deposited. If an individual, entity, or organization claims a right to be paid out of your client's recovery but this right is not created by statute, the claim is not a lien.

The first time to broach the liens and claims topic with your client is at the outset of the representation. Personal injury attorneys should make sure the client understands that liens will be protected and paid out of the settlement funds. The contract of employment should include a paragraph similar to the following:

> "I authorize and direct attorney to pay any outstanding medical bills, charges, claims and liens, including claims of health care plans and insurers, as required by law, and incurred as a result of the above incident out of any recovery obtained on my behalf."

At the conclusion of the case it is time to revisit the claims and liens issue for what should be the last time. Be sure you have language in your Disbursement Sheet that signifies the client understands and approves of the disbursement and distribution of the settlement proceeds as listed on the Sheet. Generally, the Disbursement Sheet should state that the client understands that he is responsible for any and all amounts or outstanding balances not listed on the Disbursement Sheet including, but not limited to, repayment of a subrogation interest claimed by a self-funded ERISA plan. This protective language is helpful if and when a client contacts your office after disbursement occurs because the lienholder is chasing the client for an unpaid balance.

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[1] Black's Law Dictionary 1072 (Rev. 4th ed. 1968).

The statute of limitations for a healthcare provider to enforce a lien has not been conclusively determined by the legislature or the courts. Absent a contract stating the date when payment is due, the statute of limitations for a non-lienholder healthcare provider to collect an unpaid balance is 3 years from the date of the last treatment provided so long as the provider has provided continuous treatment to the client.[2]

In North Carolina, lawyers usually face the following proverbial hands seeking money from personal injury recoveries:

- Medicare (42 U.S.C. §1395(b)(2)(A)),
- U.S. Workers' Compensation (5 U.S.C. § 8132),
- TRICARE (10 U.S.C. § 1095),
- Medicaid (N.C. Gen. Stat. §108A-57),
- Vocational Rehabilitation (N.C. Gen. Stat. § 143-547),
- N.C. Teachers and State Employees Comprehensive Major Medical Plan (N.C. Gen. Stat. § 135-40.13),
- Health Care Providers (N.C. Gen. Stat. §§ 44-49, 50),
- Ambulance Service Liens (N.C. Gen. Stat. § 44-51.8), and
- Workers' Compensation (N.C. Gen. Stat. §97-10.2).

Each lien has a different methodology for reimbursement.

I. MEDICARE

Title XVIII of the Social Security Act was enacted in 1965.[3] Its original purpose was to provide federal health insurance for senior citizens. The Medicare program now encompasses four basic groups: (1) persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits; (2) disabled persons of any age who have received Social Security, widows or Railroad disability benefits for 25 months; (3) persons with end-stage renal disease ("ESRD") who require dialysis treatment or a kidney transplant; and (4) persons over age 65 who are not eligible for either Social Security or Railroad Retirement benefits who purchase Medicare coverage by payment of a monthly premium.

There are two categories of Medicare: Part A and Part B. Medicare Part A provides coverage for hospitals, related post-hospital services, skilled nursing services, home health services and hospice care.[4] Medicare Part B is the supplemental medical insurance program covering services

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[2] *Johnson Neurological Clinic v. Kirkman*, 121 N.C. App. 326, 465 S.E.2d 32 (1996).
[3] 42 U.S.C. § 1395 *et seq*.
[4] 42 U.S.C. § 1395(c) *et seq*.

rendered by physicians, ambulances and durable medical equipment.[5] Fiscal agents of the federal government, known as "fiscal intermediaries," for Part A, and "carriers" for Part B, perform many of the administrative functions of the Secretary of Health and Human Services, the department charged with the overall administration of the Social Security Act. One of the functions of the intermediaries and carriers is of importance to practitioners: the collection of benefits paid subject to recovery. In order to fully understand Medicare's right of reimbursement, the practitioner should consult the following pertinent portions of the Social Security Action and the Code of Federal Regulations: (1) 42 U.S.C. § 1395(y); (2) 42 U.S.C. §§ 1395(ff); (3) 42 U.S.C. § 1395(gg); 31 U.S.C. § 3711; and (4) 42 C.F.R. § 405.801.

Medicare has a lien upon proceeds of first-party (medical payments, UM and UIM) and third-party claims. Pursuant to the statutory formula, Medicare liens are reimbursed in full, but can be reduced by up to one-third of the lien amount as payment for attorney's fees. Medicare will also pay its fair share of the costs in addition to attorney's fees. [Note: Medicare expects full recovery without deduction for attorney fees or costs when the source is medical payments coverage under an automobile or home insurance policy. This is so because medical payments coverage is a contractual payment obligation not dependent on negligence and attorney involvement.] Remember, Medicare's recovery is not limited by the North Carolina wrongful death statute's cap of $4,500.00 on medical expenses.[6]

Chances are the practitioner will learn from her client, the liability carrier, or the Medicare fiscal intermediary or carrier that a Medicare lien exists. If not, you should be put on notice by a number of clues, including an elderly, retired, or disabled client. Scrutinize medical and hospital billings and itemized statements to determine if Medicare benefits were received. If you suspect, but do not know of, a Medicare lien, send a letter to the fiscal intermediary to determine if any claim exists.

When Medicare pays a health care provider in a case of potential third-party liability, it refers to the payment as a conditional payment. This conditional payment becomes an overpayment when the beneficiary recovers from a primary payer, such as the third-party liability insurance carrier, or the UM/UIM carrier. The repayment of an overpayment may be reduced by the procurement costs, which include attorney's fees.[7] However, as noted above, there is no reduction for procurement costs when the payment is made under Medical payments coverage.

When the practitioner receives written notice from the fiscal intermediary as to the amount of Medicare's lien, the following questions should be considered:

- Is the statement of the lien correct?
- Is it appropriate to appeal Medicare's claim for reimbursement?
- Is it appropriate to seek pre-settlement compromise of the claim?
- Is it appropriate to seek waiver of Medicare's claim?
- Are there any equitable defenses to full recovery?

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[5] 42 U.S.C. § 1395(j) *et seq.*
[6] *Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997).
[7] 42 C.F.R. § 411.20 *et seq*.

Do not accept the fiscal intermediary's claim for reimbursement as correct. The fiscal intermediary sends plaintiff's counsel all charges Medicare paid from the time of the accident until the date of the request. Charges paid may include payments for services unrelated to the personal injury claim. Review all the charges paid by Medicare and compare them to the charges that you know are related to the personal injury claim. If you disagree with the fiscal intermediary's claim for reimbursement, return to the fiscal intermediary its printout with your notations as to the errors. You should then request reconsideration of the claim. Should you be dissatisfied with the response from the fiscal intermediary, you have the right to appeal.[8] This right of appeal pertains only to the charges for which Medicare claims reimbursement. The appeal process contemplates reconsideration by the carrier, appeal before an administrative law judge of the Social Security Administration, an appeal to the Social Security Appeals Council and finally an appeal to a United States District Court.

You also have the right to seek a pre-settlement compromise of the Medicare claim. The criteria for the compromise of a claim are set out in 31 U.S.C. § 3711 (Federal Claims Collection Act) and are as follows:

a. The cost of collection does not justify the enforced collection of the full amount of the claim;
b. There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made, or
c. The chances of successful litigation are questionable, making it advisable to seek a compromise settlement.

In a "contributory negligence" state like North Carolina, the chances of Medicare foregoing recovery are real and use of this approach is encouraged. The pre-settlement compromise is processed by the regional Office of the Health Care Financing Administration (Atlanta), although the initial submission is to the local office of the fiscal intermediary. Seeking a pre-settlement compromise will not bar you from seeking a post-settlement waiver.

Having established the correctness of the claim, and the denial of a pre-settlement compromise, the next option is to seek post-settlement waiver or compromise of the claim. The authority for waiver or compromise rests in 42 U.S.C. § 1395y(b)(2)(B)(iv), 42 U.S.C. § 1395gg(c), and 31 U.S.C. § 3711. Waivers are normally only processed when the case has been settled and the fiscal intermediary has sent out a demand letter. Before contemplating full reimbursement to Medicare, consider whether there are any equitable defenses to full reimbursement.

There are two established levels of appeal regarding Medicare's denial of a waiver request. The initial appeal is called redetermination and it must be requested in writing within 120 days of the date of the notice of denial. Redetermination is a de novo review that can include virtually any relevant evidence or authority. To the extent further appeal is desired, a written request for reconsideration must be submitted within 180 days of the date of the redetermination notice.

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[8] *See* 41 U.S.C. § 1395(ff) *et seq*.

Repayment of Medicare's lien must be made within 60 days of receipt of settlement or verdict proceeds for Part A recovery. Good practice would be to make all repayments within 60 days. Repayment does not waive the right to appeal or seek waiver or compromise of the claim. It does, however, prevent the assessment of interest charges.

Prudence and caution should compel the practitioner to view Medicare's lien as a lien on proceeds unless compelling facts and law direct otherwise. Even if there is no lien on the proceeds held by the attorney, the consequences to the client (and continuing Medicare beneficiary) can be severe. Social Security may recover its overpayment from future benefits due its beneficiary. Social Security may also seek recovery against the third-party payer (primary payer). Normally, this would be the third-party liability insurance carrier. The primary carrier will not want to subject itself to a double loss and will be reluctant to pay the beneficiary directly. Thus the carrier, at least in unrepresented cases, will want to reimburse Medicare directly. In represented cases, the carrier will pay the beneficiary's attorney only upon assurance that the attorney will reimburse Medicare out of the proceeds of the settlement.

II. U.S. WORKERS' COMPENSATION

This lien may come into play if the client was injured while on the job as a federal employee and received medical benefits. The Federal Government claims a lien upon proceeds and the source of funds in first party claims. The applicable statute is 5 U.S.C. § 8132. The statute allows the client to retain at least 1/5 of the net recovery remaining after the deduction of expenses.[9] Additionally, the statute allows for the reduction of the Federal Government's recovery by the proportionate amount of a reasonable attorney's fee. In order to receive workers' compensation benefits, the client must either pursue recovery against any responsible third party or assign his claim to the Federal Government.[10] Under this lien, the Federal Government lacks the authority to pursue an independent action against the tortfeasor.

III. TRICARE (formerly known as CHAMPUS)

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

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

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[9] 5 U.S.C. § 8132.
[10] 5 U.S.C. § 8131(b).

beneficiary reaches Medicare age, TRICARE benefits cease. Thus, a 65-year old veteran would no longer be qualified to receive TRICARE benefits, but his 55-year old wife would be qualified.

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

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

The TRICARE lien is subject to adjustment and can be reduced or waived by the Claims Recovery Office when justice requires. There is no deduction permitted for attorneys' fees, and there is no cap on the amount of the lien. By law, a Claims Recovery Officer has initial limited authority to compromise or waive the lien.

Whether a TRICARE lien will be compromised will ultimately depend on how much the beneficiary will receive. For instance, if the proposed compromise would reap few benefits to the beneficiary but more to the attorney, chances of compromise will be slim. On the other hand, if there is a recovery for less than the full value of the claim and other lienholders or claimants (including attorneys) are willing to adjust their claims, chances of a compromise with the Claims Recovery Office improve. The plaintiff's attorney should keep in close contact with the Recovery Office and plead the case for compromise armed with sufficient facts and arguments to justify an adjustment.

The dollar amount limits of the local Claims Recovery Officer's authority to compromise a claim are subject to adjustment. Further, each service has its own methodology which it follows, and some services require more supporting documents than others, especially when compromising a large claim. KEYNOTE: Federal law prohibits payment of an attorney fee for assertion or collection of a claim by the government.[11]

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[11] 5 U.S.C. § 3106.

IV. MEDICAID

Medicaid is a "welfare" program administered by the State of North Carolina. Eligibility depends on such factors as income level, available financial resources, and other criteria. Generally, health care providers are not required to accept Medicaid patients. However, if they accept Medicaid patients, they must accept Medicaid payments in full, except for certain specific services for which a co-payment may be charged. If a provider itemized the charges for a particular course of treatment and submitted only some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items.

The Medicaid lien is created by N.C. Gen. Stat. § 108A-57. Medicaid claims a lien against any source, including payments made under the claimant's own medical payments coverage, uninsured coverage, and underinsured coverage.[12] Medicaid has a statutory right of subrogation and can make claim and sue the tortfeasor directly.[13] It is a lien against the source of proceeds and the recovery itself. The statute allows no deduction for attorney's fees, but Medicaid cannot receive more than one-third of the plaintiff's recovery.

There have been some recent happenings with respect to the scope of Medicaid liens. The case of *Ezell v. Grace Hospital* (175 N.C. App. 56, 623 S.E.2d 79 (2005)) represents the most expository and recent North Carolina judicial affirmation of the broad reach of Medicaid liens. In this case a dissent by Justice Steelman of the North Carolina Court of Appeals was adopted by the North Carolina Supreme Court.[14] Justice Steelman departed from the majority and rebuffed a plaintiff's attempt to limit Medicaid's recovery to a portion of the medical bills found to be causally related to the negligence of the tortfeasor.

It is worth noting that less than 60 days before the North Carolina Supreme Court's *Ezell* decision the United States Supreme Court addressed the same legal issue in the case of *Arkansas Department of Health and Human Services v. Ahlborn* (547 U.S. 268, 126 S.Ct. 1752 (2006)). The U.S. Supreme Court held that Federal law capped Medicaid's lien to the amount of the settlement attributable to the recovery of medical expenses. The latest chapter in this installment was the North Carolina Supreme Court's December 2006 denial of a petition to rehear the *Ezell* case. This denial is especially perplexing since a rehearing by the Court could have clarified the scope of Medicaid liens in North Carolina. Until such clarification, North Carolina attorneys should be prepared for Medicaid's continued position that their lien stretches to the entirety of the settlement proceeds. Stay tuned for further developments in this area.

The formula for reimbursement to Medicaid is slightly different than the reimbursement formula to Medicare (save for the possible one-third recovery cap suggested above). Medicare will pay its fair share of legitimate costs associated with the recovery even if those costs are not taxed by judgment. On the other hand, N.C. Gen. Stat. § 108A-57(a) would suggest that such

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[12] N.C. Gen. Stat. § 108A-59.
[13] *Malloy v. Durham County Dept. of Social Services*, 58 N.C. App. 61, 293 S.E. 2d 285 (1982).
[14] *Ezell v. Grace Hospital*, 360 N.C. 529, 631 S.E.2d 131 (2006).

costs are only recognized when "taxed by judgment." Furthermore, Medicare allows for hardship reduction of the reimbursement amount, but N.C. Gen. Stat. § 108A-57 does not allow for such a reduction. Finally, while Medicare will in some circumstances grant a lien waiver, Medicaid will **not** waive liens.

Actual notice of a Medicaid lien is not required; constructive notice is sufficient.[15] "Constructive notice" includes but is not limited to an attorney's receipt of a medical bill that references Medicaid filing or payment. If you suspect that Medicaid has paid any medical or hospital bill for your client, review all medical and hospital billings and charge statements to determine if Medicaid submission was made or Medicaid benefits received. Write to the North Carolina Department of Human Resources, Third-Party Recovery Section, to determine if there is a lien. The Third-Party Recovery Section will send you a written statement of its payments. Do not automatically assume this statement is correct. Like Medicare, Medicaid's statement shows all charges they paid from the date of the accident until the date of the request, using best efforts to determine related charges. You need to compare Medicaid's claim against the accident-related bills and advise Medicaid of any unrelated payments. Simply review Medicaid's statement and flag or otherwise indicate the payments that are unrelated to the accident. Mail your "audited copy" of the statement back to the Third-Party Recovery Section. Generally speaking, Medicaid is very understanding with regard to contested payments. If a provider itemized the charges for a particular course of treatment and submitted only some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items.

V. VOCATIONAL REHABILITATION

This lien is created by N.C. Gen. Stat. § 143-547. Vocational Rehabilitation claims a lien against any source, including payments made under the claimant's own medical payments coverage, uninsured motorist coverage, underinsured motorist coverage, personal insurance, workers' compensation, or any other source. Vocational Rehabilitation takes the position that it has a statutory right of subrogation and can make a claim and sue the tortfeasor directly. You should also review all medical and hospital or rehabilitation facility records, billing and charge statements, to determine if Vocational Rehabilitation is involved.

The Vocational Rehabilitation lien only applies in those cases where a financial needs test was administered in order to receive benefits. If no financial needs test was required, then no lien attaches pursuant to N.C. Gen. Stat. § 143-547(c).

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

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

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

VI. N.C. TEACHERS AND STATE EMPLOYEES COMPREHENSIVE MAJOR MEDICAL PLAN

This lien was created in 2004 by N.C. Gen. Stat. § 135-40.13A. The Plan is entitled to recover the full amount of any "...hospital, surgical, medical, or prescription drug expenses" but it will reduce its recovery by the "...proportionate share of the costs of collection" which should include attorneys' fees and expenses. There is a presumption that a 33 1/3% attorneys' fee is reasonable and any higher fee amount will need to be sufficiently documented and justified before the Plan will consider such.

No actual notice is required in order for the lien to exist. Constructive notice (ex: attorney realizes client or the primary insured under the Plan is a state employee + attorney sees notation of Blue Cross/Blue Shield payments on medical bills) is sufficient. The entity with whom you will be dealing regarding a Plan's claim or lien is Public Consulting Group, Inc. (www.PublicConsultingGroup.com).

The lien statute has been revised and, consequently, there are differing rules depending on the date that **the Plan paid claims for your client**. NOTE: The date of service is irrelevant for the purpose of determining if a lien exists. The relevant date is the date the Plan made payment on a claim. Thus you may need to review medical bills and/or contact healthcare providers to determine the dates on which the Plan made payments for your client's various injury-related expenses.

For claims paid prior to January 22, 2004: Plan is inconsistent in seeking reimbursement for these claims. The Plan likely realizes it lacks clear and convincing evidence that the law entitles it to reimbursement. The prudent thing would be to advise your client of the Plan's weakened position with respect to seeking reimbursement and allow the client to decide how to proceed. To the extent your client instructs you not to pay the Plan's claim out of settlement proceeds, be sure to advise your client of the potential consequences of her decision and have her sign a document acknowledging the existence of these potential consequences and reflecting her instructions.

For claims paid on January 22, 2004 to July 20, 2004, inclusive: no lien yet the Plan claims a right of equitable subrogation. As you should already know, this is not the same as a lien. Accordingly, for claims paid during this approximately six month period, you should handle the Plan's claim as you would the claim of an ERISA plan. As noted above, a client's decision to disallow payment to the Plan should be properly documented and signed.

For claims paid by the Plan after July 20, 2004: lien exists. This much is quite clear.

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

The Plan claims a right of priority on any amounts the Plan member recovers but one should assume that federal liens (ex: Medicare, TRICARE, U.S. Workers Compensation) take priority over the Plan's lien. The Plan's lien, however, would appear to take priority over healthcare provider liens. Therefore, in the context where all available proceeds for lienholders would be payable to the Plan, the attorney should notify the healthcare providers of this fact. By so doing, the attorney would have discharged her ethical and legal obligations but the attorney should remind the client that the client remains responsible for these unpaid balances held by the healthcare provider lienholders.

Thanks to a recent revision of the North Carolina wrongful death statute (N.C. Gen. Stat. §28A-18-2), the Plan's lien recovery is not subject to the statute's $4,500.00 cap on payment of medical expenses. Similar to workers' compensation carriers, the Plan has the right to pursue recovery directly against a third party in the event the Plan member does not pursue a claim.

VII. HEALTH CARE PROVIDERS

SCENARIO #1: CLIENT HAS NO ATTORNEY + CLIENT SIGNS ASSIGNMENT OF PROCEEDS OF PI CLAIM = LIEN

Charlotte-Mecklenburg Hospital Authority v. First of Georgia Insurance Company et al., 112 N.C. App. 828, 436 S.E.2d 869, *rev'd*, 340 N.C. 88, 455 S.E.2d 655 (1995), recognized, in a case where the patient who was not represented by counsel, a valid lien created by a healthcare provider against proceeds in the hands of the liability carrier. The lien was "created" because the injured victim signed an assignment of the proceeds of a personal injury action and the liability carrier was put on notice of such an assignment. *First of Georgia* could also be construed to mean an assignment creates a valid lien against the proceeds in the hands of UM and UIM carriers, at least in those cases when no attorney is involved in distributing the proceeds.

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

SCENARIO #2: CLIENT HAS ATTORNEY + CLIENT HAS NOT SIGNED ASSIGNMENT OF PROCEEDS OF PI CLAIM = LIEN POSSIBLE

First of Georgia seems to suggest that any lien created by an assignment may evaporate once the client hires an attorney. Once an attorney is retained the lien and disbursement protocol would be that as outlined in N.C. Gen. Stat. §§ 44-49, 44-50. N.C. Gen. Stat. §§ 44-49, 44-50 cover liens claimed by physicians, hospitals, nurses, dentists, ambulance services and seemingly any entity which has provided health care services related to the injury for which your client has recovered. Although chiropractors are not listed in N.C. Gen. Stat. §§ 44-49, 44-50, their liens are likely covered.[16]

The requirements for a healthcare provider to have a lien under N.C. Gen. Stat. §§ 44-49, 44-50 are as follows:

- Attorney requests client's medical records or itemized bill from healthcare provider AND
- Healthcare provider provides attorney with client's medical records or itemized bill free of charge AND
- Healthcare provider provides attorney with written notice of the lien claimed.

After determining which healthcare providers have liens under N.C. Gen. Stat. § 44-49(b), you should determine if there is enough money to pay your fee and expenses, repay the lienholders in full as well as any other unpaid bills that your client wishes to be paid, and allow your client to receive the largest "share" of the proceeds. After all, it is your client who suffered the painful injuries and underwent the medical treatment and may face future complications. If you have enough money to go around, you can do the traditional math. If not, you will need to turn to the help provided by N.C. Gen. Stat. § 44-49 and 44-50. These statutes create a cap on the amount healthcare provider lienholders can extract from your client's recovery. Under N.C. Gen. Stat. § 44-49 and 44-50, in no event may the total liens exceed one-half of the remainder of the client's recovery after deduction for attorney's fees. In other words, after deducting your attorneys' fee (sorry, the statute does not allow for the "up front" deduction of your expenses), the client is entitled to receive 50% of the remaining funds which leaves the other 50% to be divided amongst lienholders. N.C. Gen. Stat. § 44-51.1 (2003) seems to require pro-rata distribution to lienholders. Arguably, for liens perfected prior to October 1, 2003 pro-rata distribution is not required.[17]

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[16] *See Triangle Park Chiropractic v. Battaglia*, 139 N.C. App. 201, 532 S.E.2d 833, *review denied*, 352 N.C. 683, 545 S.E.2d 728 (2000).
[17] *See North Carolina Baptist Hospital v. Crowson*, 155 N.C. App. 746, 573 S.E.2d 922 (2003).

Let's use an example to illustrate a pro rata distribution:

Example: Client is injured in a motorcycle collision and incurs medical expenses resulting in liens of $10,000 by Community Hospital, $9,000 by Doctor Fixit, $300 by County EMS, $2,500 by See-Thru Radiology and $4,000 by Work-It-Out Physical Therapy. Client hires you to represent him and you agree to recover a 33 1/3% contingent fee plus payment of your expenses. After negotiating with the adverse insurance company, you obtain a $60,000.00 settlement. Your case expenses are in the amount of $100.

Step 1: Calculate total money owed to lienholders. $10,000 + $9,000 + $300 + $2,500 + $4,000 = $25,800. If you were to pay all parties "straight up", your settlement sheet would appear as follows:

$60,000	Settlement proceeds
$20,000	Attorneys' fee
$100	Attorney expenses
$25,800	payments to lienholders
$14,100	proceeds to client

This is the classic case of "too many liens, too little money". Given your ethical obligation to represent and protect your client, you should seek the protections of N.C. Gen. Stat. § 44-49 and 44-50

Step 2: Calculate total recovery proceeds available to lienholders. $60,000.00 minus attorneys' fee of 33 1/3% or $20,000 equals $40,000. 50% of $40,000 equals $20,000.00. Thus $20,000 is available to lienholders.

Step 3: Determine the pro-rata amount to be paid to each lienholder. Set the pro-rata ratio to be used to calculate for each lienholder as follows:

$$\frac{\text{Lien amount for lienholder}}{\text{Total amount of all liens}} = \frac{X}{\text{Total funds available to lienholders}}$$

For each lienholder, round the formula result to two decimal places. The result should equal the "pro rata" money that each lienholder should receive. To check your math, add up all of the "pro rata" amounts to be paid to the lienholders and you should garner a result pretty close to the amount of the available funds. You may have to do a bit of rounding to make the numbers accurate to the penny.

Based on the above formula, the pro-rata amounts to be paid to the respective providers is as follows:

Community Hospital	$7,751.94
Doctor Fixit	$6,976.75
County EMS	$232.56
See-Thru Radiology	$1,937.98
Work-It-Out PT	$3,100.77

N.C. Gen. Stat. § 44-51.1 creates an affirmative obligation of the attorney to provide "less than paid in full" lienholders documentation of the following: (1) total settlement proceeds, (2) all lien amounts, (3) distribution amounts to respective lienholders, (4) for each lienholder, the percentage of its lien amount that is represented by the distribution amount, and (5) total amount of attorneys' fees. A pro-rata or other payment [to a lienholder] that is less than the lien amount does not absolve the client from the obligation to pay the unpaid balance on the lien. Additionally, failure of a healthcare provider to perfect a lien does not absolve the client from the obligation to pay the unpaid charges.

If a valid lien is created under N.C. Gen. Stat. §§ 44-49, 44-50, the lienholder has an enforceable claim against the plaintiff's disbursing attorney, should that attorney fail to honor the lien. This claim is in addition to the claim the health care provider has against the client/patient.[18] Where the lien amount is in dispute no payment is required "..until the claim is fully established and determined."[19]

It is recommended that practitioners encourage payment of all medical bills when there are sufficient recovery proceeds. The employment contract recommended above should facilitate this approach. However, if the client instructs his attorney not to pay non-lienholder healthcare providers, then the attorney must follow those instructions even if the original employment contract provides otherwise.[20] As for healthcare provider lienholders, if the claim is liquidated (i.e. clear and certain), the lawyer may pay the provider over the client's objection. If the client disagrees, the attorney should file an interpleader action and pay the disputed funds into the court for resolution by the court. While clearly available, however, the interpleader remedy should be utilized only as a last resort. Try to iron out the dispute between your client and the lienholder so you, the client, and the lienholder can close the chapter and move on with your respective lives.

SPECIAL NOTE: Entities not entitled to payment under N.C. Gen. Stat. § 44-49 and 44-50:

1. Healthcare providers who have received payments from Medicaid. Be on the lookout for any of your client's medical bills that have the language "MEDICAID RECIPIENT; BENEFITS ASSIGNED" or something similar. This language means the healthcare provider has filed a claim with Medicaid for payment of certain treatment or services provided. A healthcare provider who has received payment from Medicaid for a specific service or treatment cannot assert a lien against your client's recovery for the unpaid balance of the same service or treatment except for certain specific services for which a co-payment may be charged. You need not honor the lien claimed by the healthcare provider and be sure to inform your client that he does not owe the "balance" either. Any balance is essentially waived or erased by the healthcare provider's acceptance of Medicaid benefits.

Balance billing is strictly prohibited as affirmed by a Sixth Circuit opinion in the case of *Spectrum Health Continuing Care Group v. Anne Marie Bowling Irrevocable Trust*, 6th Cir., 410

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[18] *See Triangle Park Chiropractic v. Battaglia,* supra.
[19] N.C.G.S. § 44-51.
[20] *See* RPC 69 and RPC 125

F.3d 304 (2005). Though not binding on a North Carolina court, the Spectrum decision and the fact that no United States court has ever allowed a provider to recover on "balance billing" should squash the provider's claim in your case.

2. Healthcare providers who have filed with a workers' compensation carrier or employer. A health care provider cannot seek recovery from the client for services provided due to a work-related injury "unless the employee's claim or the treatment is finally adjudicated not to be compensable or the employee fails to request a hearing after denial of liability by the employer."[21] A health care provider who seeks to recover payment on a bill incurred by an employee due to treatment for work-related injury could face conviction of a Class 1 misdemeanor.[22]

SPECIAL SITUATION: Lien laws of other states

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

VIRGINIA: A healthcare provider can have a valid lien against your client's recovery but not to exceed the amount of $2,000.00 in the case of a hospital and $500 in the case of a physician, nurse, physical therapist, or pharmacy.[23] In order to create a lien the healthcare provider must provide the attorney or client with written notice of lien unless the client's attorney knows medical services were either provided or paid for by the Commonwealth of Virginia.[24] Like N.C. Gen. Stat. § 44-49, the Virginia Code does not specifically state that the notice of lien contain the amount of the lien claimed. Although a good faith argument can be made that a notice of lien is fatally defective if no actual lien amount is stated, you should assess whether it is advisable to just contact the healthcare provider and obtain the amount of their lien.

SOUTH CAROLINA: House Bill 3729 was introduced in 2005 and is still pending. The bill has detailed provisions which, among other things, would create a lien against third party recoveries and allow clients to grant an assignment of proceeds of a personal injury claim. Practitioners handling claims in which medical treatment and services were provided in South Carolina should monitor the South Carolina legislature for any new developments.

TENNESSEE: Tennessee Code § 29-22-101 *et seq*. relate to hospital liens. The lien is capped at 1/3 of the damages recovered and in order to perfect a lien, within 120 days of the

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[21] N.C. Gen. Stat. § 97-90(e).
[22] N.C. Gen. Stat. § 97-88.3(c).
[23] Virginia Code § 8.01-66.2.
[24] Virginia Code § 8.01-66.5.

patient's release from the hospital, a hospital must file a notice of lien with the clerk of court in the county in which the hospital is located.[25] There is no requirement that the hospital send any notice of lien to the attorney or the client.

VIII. AMBULANCE SERVICE LIENS

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

Ambulance service liens must be filed with the Clerk of Superior Court in order to be perfected. Ambulance service liens can be asserted versus real property only if the lien was filed with the Clerk of Superior Court within 90 days after the date service was furnished.[26] The county can utilize garnishment or attachment proceedings to recover the lien amount from your client if the lien was filed with the Clerk of Superior Court within 91 to 180 days after the date service was furnished.[27] This means the county could take your client's wages, bank deposits, personal property, etc.). A county's failure to file their outstanding bill with the Clerk of Superior Court within the requisite time period means only that the county cannot undertake the aforementioned procedures to recoup its money. The county would retain a lien under N.C. Gen. Stat. § 44-49 and 44-50. The lien exists for 10 years from the date the service was furnished or 3 years from the date of the recipient's death.[28]

IX. N.C. WORKERS' COMPENSATION

Workers compensation benefits received by your client, whether medical benefits paid or indemnity payments or other benefits, create a lien against any recovery your client receives from a third-party tortfeasor for an on-the-job injury.[29] It appears that even a recovery of uninsured or underinsured motorist monies would be subject to a workers' compensation lien.[30]

You are allowed to deduct attorneys' fees and office expenses from the workers' compensation lien.[31] The amount, however, of the attorneys' fee to be deducted cannot exceed one-third of the recovery.[32] The statutes also provide for the employer to pay its fair share of costs and expenses incurred by the attorney obtaining the recovery.

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[25] T.C.A. § 29-22-102.
[26] N.C. Gen. Stat. § 44-51.2.
[27] N.C. Gen. Stat. § 44-51.6.
[28] N.C. Gen. Stat. § 44.51.1.
[29] N.C. Gen. Stat. § 97-10.2.
[30] *See Creed v. R.G. Swaim & Son*, 123 N.C. App. 124, 472 SE2d 213 (1996); *Bailey v. Nationwide*, 112 N.C. App. 47, 434 SE2d 625, *aff'd*, 334 NC 1, 430 SE2d 895 (1993).
[31] N.C. Gen. Stat. § 97-10.2(f)(1).
[32] N.C. Gen. Stat. § 97-10.2(f)(1)b.

WORKERS' COMPENSATION

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

STEP 2 — After determining the amount of recoverable charges that will compose the lien, contact the carrier regarding a reduction of the lien amount. You should seek to negotiate a reduction of repayment on virtually all workers compensation liens. [NOTE: If you seek to reduce the lien repayment amount, you must do this before you have your client sign a compromise settlement agreement that is approved by the Industrial Commission. Once the Commission approves the settlement agreement, it is too late.[33]]

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

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

STEP 3b — If you are unable to reach an agreement with the workers' compensation carrier regarding a reduced lien repayment amount, do not despair. If the employee's workers' compensation claim was accepted after October 1, 1990, N.C. Gen. Stat § 97-10.2(j) allows the employee to petition a Resident or Presiding Superior Court Judge to set the subrogation amount, if any, to be paid to the employer or insurance carrier after proper notice to the employer. The statute states that the judge has the right to determine the amount of reimbursement in his/her "discretion". If the third party case is pending in Federal court, your petition must be made therein. The Industrial Commission cannot order the carrier to accept less than the statutory lien amount. Only a judge has this authority. After a judicial decision on your petition, you must still prepare an application and proposed order to the Industrial Commission approving disbursement.

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

X. THE SPECIAL CASE of ERISA

The Employment Retirement Income Security Act of 1974[34] allows employers to establish self-funded health care and disability plans that are not subject to state insurance regulations or other state interference. If the applicable state has a law or rule limiting subrogation rights, such laws are abrogated by ERISA which preempts the field. Those employers who provide welfare benefits to their employees under or through a qualified self-funded ERISA plan may, but are not required to, seek reimbursement or subrogation for their plans.

First and foremost, an ERISA claim is not a lien and thus repayment of an ERISA plan's claim is not automatic. There may be exceptions such as when the attorney represents to the ERISA plan provider that the provider's claim will be 'protected' or the attorney otherwise misleads the plan provider. The attorney should NEVER sign any letter, agreement or other document that binds her to represent the plan's interests. Such an agreement would pose an indomitable conflict of interest as the attorney would thereby have two competing masters with respect to payment of settlement proceeds---the client and the plan.

The attorney facing a subrogation claim by a health plan must insist on reviewing all of the pertinent documents including the IRS Form 5500, the Summary Plan Description (SPD), and the underlying plan language. Once you have the IRS Form 5500, direct your attention to Line 9a that specifies the plan's funding arrangement. If the box number 1, "Insurance", is selected, the plan may be out of luck and you may be home free. North Carolina's anti-subrogation regulation prohibits the insured plan from seeking reimbursement.[35] The Court of Appeals has upheld this regulation. In The Matter Of: A Declaratory Ruling By The North Carolina Commissioner Of Insurance Regarding 11 N.C.A.C. 12.0319, 134 N.C. App. 22, 517 S.E.2d 134 (1999). Virginia also prevents subrogation provisions in health insurance contracts.[36]

If box numbers 2, 3, or 4 are selected on the Form 5500, the plan is likely self-funded and thereby entitled to reimbursement. Even though this may be the case and the plan demands reimbursement in its correspondence to your office, do not automatically assume that the plan language calls for reimbursement. Read the plan language fully to determine if a reimbursement provision exists.

If there is a reimbursement/subrogation provision, what does it say? If the SPD language differs from the plan language the latter controls. Following one of the basic principles of contract law, any ambiguous plan language should be construed against the drafter—the plan. Read the potential sources from which the plan seeks recovery – tortfeasor, uninsured motorist carrier, underinsured motorist carrier, medical payments, etc.-- to see if they actually affect your client.

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[34] 29 U.S.C. 20 § 1001 *et seq*.
[35] *See* 11 N.C.A.C. 12.0319.
[36] *See* Virginia Code § 38.2-3405.

The law regarding the rights, duties and obligations of the ERISA plans, beneficiaries and attorneys for the beneficiaries is ever-evolving. Plans have now become more savvy and many are requiring plan beneficiaries to sign agreements to repay benefits prior to the plan paying for medical claims. Plans are increasingly filing suit versus clients and attorneys in an effort to recover their reimbursement money. The courts have held the beneficiary/client liable but not the disbursing attorney. *The Great West Life & Annuity Ins. Co. v. Knudson* 534 U.S. 204, 122 S.Ct. 708 (2002), case teaches us that attorneys should move swiftly in disbursing settlement funds so as to minimize the risk of the funds being frozen by a judicial imposition of a constructive trust at the behest of the ERISA plan. The wisdom of this tactical approach has been reaffirmed by the United States Supreme Court's affirmance of the imposition of an equitable constructive trust (called an "equitable lien" throughout the Court's opinion) against proceeds in the possession of the client.[37]

In the end, the ERISA topic is one that clearly requires a frank discussion with the client and a signed written directive by the client. Given the lengths that some plans have gone to in an effort to obtain reimbursement, the best policy is to encourage the client to resolve the matter with the plan. In the end, however, since the ERISA claim does not rise to the level of a lien, the client has the final say on how to proceed.

REVIEW OF DISBURSEMENT RULES

- If a lien exists and client instructs you to pay the lien, pay the lien.
- If a lien exists but client instructs you not to pay the lien—STOP! You should retain sufficient money in your client trust account to pay the lien.[38] The client and the lienholder should resolve their dispute before you disburse the funds. If the dispute cannot be resolved, you may pay the lienholder over the client's objection,[39] or you may choose to seek the interpleader remedy under Rule 22 of the North Carolina Rules of Civil Procedure.
- If no lien exists but client instructs you to pay the claimed amount, pay the outstanding claim but consider requesting a reduction of the claimed amount.
- If no lien exists and client instructs you not to pay the claimed amount, do not pay the claimed amount. You must abide by the instructions of your client with respect to disbursement of settlement funds unless the funds are subject to a valid lien. Be sure to remind your client (preferably in writing on the Disbursement Sheet that she signs) that she remains solely responsible for any unpaid bills.

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[37] *Sereboff v. Mid Atlantic Medical Services Inc.*, 547 U.S. ____, 126 S.Ct. 1869 (2006).
[38] RPC 75
[39] RPC 69

RPC 69

October 20, 1989

Payment Of Client Funds To Medical Providers

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

Inquiry:

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

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

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

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

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

Opinion:

Rule 10.2(E) of the North Carolina Rules of Professional Conduct [Rule 1.15.2 of the Revised Rules] provides that, "[A] lawyer shall promptly pay or deliver to the client or to third persons as directed by the client the funds, securities, or properties belonging to the client to which the client is entitled in the possession of the lawyer." A lawyer is generally obliged by this rule to disburse settlement proceeds in accordance with his client's instructions. The only exception to this rule arises when the medical provider has managed to perfect a valid physician's lien. In such a situation the lawyer is relieved of any obligation to pay the subject funds to his or her client, and may pay the physician directly if the claim is liquidated, or retain in his or her trust account any amounts in dispute pending resolution of the controversy.

In those cases where the client has authorized the lawyer to represent to the medical provider that the provider's fees will be paid from the proceeds of settlement and thereafter forbids the lawyer to pay the physician, the lawyer is, as the client's agent and trustee of the client's funds, under an obligation to comply with the client's instructions. If the lawyer is of the opinion that he might thereby be facilitating his client's fraud, it would not be inappropriate for the lawyer to advise the medical provider of the client's change of heart in sufficient time for the medical provider to pursue any remedies it might have in anticipation of the disbursement of the settlement proceeds. *See* Rule 4(c)(4) [Rule 1.6(d)(5)]. Should no action be taken by the medical provider within a short specified time, the lawyer would then be obligated to comply with his or her client's instructions. *See also N.C. Baptist Hospitals v. Mitchell*, 323 N.C. 528 (1989).

RPC 75

October 20, 1989

Disbursement of Client Funds

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

Inquiry:

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

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

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

Opinion:

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

RPC 125

January 17, 1992

Disbursement of Settlement Proceeds

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

Inquiry:

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

Opinion:

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

RPC 228

July 26, 1996

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

Indemnifying the Tortfeasor's Liability Insurance Carrier for Unpaid Liens of Medical Providers as a Condition of Settlement

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

Inquiry:

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

Opinion:

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

RPC 231

October 18, 1996

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

Collecting a Contingent Fee on the Gross Recovery and on the Medical Insurance Provider's Claim

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

Inquiry #1:

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

Opinion #1:

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

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

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

…

(4) the amount involved and the results obtained;

(5) the time limitations imposed by the client or by the circumstances;

…

(7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and

(8) whether the fee is fixed or contingent.

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

Inquiry #2:

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

Opinion #2:

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