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To Clients and Friends of Matthiesen, Wickert & Lehrer, S.C.: *This monthly electronic subrogation newsletter is a service provided exclusively to clients and friends of Matthiesen, Wickert & Lehrer, S.C. The vagaries and complexity of nationwide subrogation have, for many lawyers and insurance professionals, made keeping current with changing subrogation law in all fifty states an arduous and laborious task. It is the goal of Matthiesen, Wickert & Lehrer, S.C. and this electronic subrogation newsletter, to assist in the dissemination of new developments in subrogation law and the continuing education of recovery professionals. If anyone has co-workers or associates who wish to be placed on or removed from our e-mail mailing list, please provide their e-mail addresses to Jamie Breen at* ***jbreen@mwl-law.com****. We appreciate your friendship and your business.*

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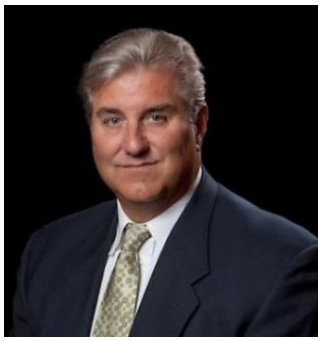

TENNESSEE SUPREME COURT DOUBLES DOWN ON QUESTIONABLE FUTURE CREDIT DECISIONS

Cooper v. Logistics Insight Corp., 2013 WL 163976 (Tenn. 2013)

By Gary L. Wickert

For four decades, a workers' compensation carrier's right to a future credit in Tennessee has been chipped away at and limited in its scope. On January 16, 2013, the Tennessee Supreme Court was given a chance to correct its own mistakes and right wrongs which have complicated workers' compensation subrogation in Tennessee for decades. It chose to double down on a series of questionable decisions, continuing a long line of judicial legislating which has harmed future credits in that state.

Tenn. Code Ann. § 50-6-112 is clear when it comes to future credits. When the employee makes a third-party recovery, the workers' compensation carrier is entitled to a credit under § 50-6-112(c)(2) against *any* future benefits – indemnity or medical – in the amount of the employee's "net recovery." *Cooper v. Logistics Insight Corp.*, 2013 WL 163976 (Tenn. 2013). The carrier can cease payment of medical and indemnity benefits until the employee's "net recovery" from the third party is exhausted or until the carrier's obligation to pay future benefits is exhausted. The "net recovery" is the total amount collected by the employee in the tort action against the third party, less reasonable expenses, including attorneys' fees. *Cross v. Pan Am World Servs., Inc.,* 749 S.W.2d 29 (Tenn. 1987), *overruled on other grounds by Summers v. Command Sys., Inc.*, 867 S.W.2d 312 (Tenn. 1993).

A workers' compensation carrier is entitled to a future credit out of any third-party settlement, in the amount of the "net recovery" by the employee, without regard to whether the employee is made whole. In

circumstances in which a carrier has not discharged its "full maximum liability for workers' compensation," § 50-6-112(c)(2)(3) provides an employer with a *"credit on the employer's future liability, as it accrues, to the extent that the net recovery collected exceeds the amount paid by the employer."* Tenn. Code Ann. § 50-6-112(c)(2); *Cooper*, supra. Tenn. Code Ann. § 50-6-112(c)(2) and (3) reads:

> *(2) In the event the net recovery by the worker, or by those to whom the worker's right of action survives, exceeds the amount paid by the employer, and the employer has not, at the time, paid and discharged the employer's full maximum liability for workers' compensation under this chapter, the employer shall be entitled to a credit on the employer's future liability, as it accrues, to the extent the net recovery collected exceeds the amount paid by the employer.*
>
> *(3) In the event the worker, or those to whom the worker's right of action survives, effects a recovery, and collection of that recovery, from the other person, by judgment, settlement or otherwise, without intervention by the employer, the employer shall nevertheless be entitled to a credit on the employer's future liability for workers' compensation, as it accrues under this chapter, to the extent of the net recovery.*

For the purposes of a carrier's future credit, an employee's "net recovery" is *"the total amount collected by the employee in the tort action [against the third party], less reasonable expenses, including attorneys' fees." Cross,* supra. However, previous Supreme Court decisions have brought the extent of this future credit into question.

For four decades, Tennessee placed serious and ill-conceived limitations on a carrier's future credit with regard to future medical. Understanding these limitations requires a look back at the history of § 50-6-112 and its predecessor statutes.

In 1950, an injured employee was entitled to medical benefits paid by his employer for a period not to exceed six months after the injury. Tenn. Code Ann. § 6875 (1950). Liability for medical benefits could not exceed $800, and the total liability for workers' compensation benefits could not exceed $7,500. Tenn. Code Ann. §§ 6875, 6878(e) (1950). The law has been amended numerous times to increase the time period for which the employer is responsible for the employee's medical care and to increase the total amount of medical benefits an employee may receive. In 1977, the General Assembly removed the limitation on the duration of medical benefits, thereby opening the door to future medical benefits to the employee that were unlimited in both duration and amount. Act of May 19, 1977, ch. 417, § 1, 1977 Tenn. Pub. Acts 1039, 1040.

The statute governing suits against third-party tortfeasors (currently § 50-6-112) also has undergone changes. The Workers' Compensation Law originally provided that an injured employee must elect to pursue a remedy against either the employer or the third party responsible for his injury. *Millican v. Home Stores, Inc.,* 270 S.W.2d 372 (Tenn.1954)(citing Tenn. Code Ann. § 6865 (1932)). In 1949, that election was removed and an injured employee could pursue both simultaneously. Act of April 14, 1949, ch. 227 § 1, 1949 Tenn. Pub. Acts 897, 897-98. The amended statute provided for the first time that an employer was *"subrogated to the extent of the amount paid or payable under this chapter."* *Id.* In 1954, the Tennessee Supreme Court in *Millican* construed the statute to provide a credit against workers' compensation benefits owed to the employee. *Millican,* supra. However, the *Millican* case involved death benefits, not future medical expenses.

In 1956, the Supreme Court in *Reece v. York*, followed the clear language of the statute and held that the carrier was entitled to a future credit and could suspend future indemnity payments until its future credit – in the amount of the balance of the employee's recovery – was exhausted. *Reece v. York,* 288 S.W.2d 448 (Tenn. 1956). *Reece* held that workers' compensation installment payments (such as indemnity benefits) are to be deferred and not commence until the sum total of the net credits of weekly installments that would have accrued from the date of the injury would be equal to the net credit, rather than taking a lump-sum future credit at the beginning of the payments. Future medical benefits were not at issue in *Reece,* and later decisions would say it is unlikely that future medical benefits were considered. *Cooper v. Logistics Insight Corp.*, 2013 WL 163976 (Tenn. 2013).

In 1963, § 50-914 (redesignated in 1983 as § 50-6-112) was amended to clearly provide as follows:

…if the employee's recovery in a suit against a third party exceeds the amount paid by the employer, and the employer has not, at [that] time, paid and discharged his full maximum liability for [workers'] compensation ..., the employer shall be entitled to a credit on his future liability, as it accrues, to the extent the net recovery collected exceeds the amount paid by the employer. Tenn. Code Ann. § 50-914 (1963) (redesignated in 1983 as § 50-6-112).

At that time, the employer was required to provide medical benefits for a maximum of one year, and the medical benefits provided could not exceed $1,800 plus $700 for "unusual medical expenses." *Reece*, supra. The amendment codified the *Reece* decision.

In 1971, the Supreme Court in *Royal Schmid* held the carrier's future credit is allowable even though it may equal and thus terminate the carrier's future liability for future death benefits. *Royal Indem. Co. v. Schmid,* 474 S.W.2d 647 (Tenn. 1971). In 1972, the Supreme Court in *Beam* confirmed that the intent of the legislature was to "reimburse an employee for payments made under [the Act] from 'the net recovery' obtained by the employee." *Beam v. Maryland Cas. Co.,* 477 S.W.2d 510 (Tenn. 1972). However, this too, was a death case which did not involve future medical benefits.

In 2000, error crept into the future credit issue when the Tennessee Supreme Court decided the case *Graves v. Cocke County*, 24 S.W.3d 285 (Tenn. 2000). The Court in *Graves* held that the credit provided for in § 50-6-112 does *not* encompass future medical payments when the employer and employee settle the compensation claim for a lump sum award. *Id*. Instead of following the clear language of the statute, the Court legislated from the bench by fabricating four "policy considerations" as follows:

(1) that employees will be restrained from spending their workers' compensation benefits "for fear that some or all of those benefits may have to be returned to the employer if needed medical treatment is sought;"
(2) employers might seek reimbursement and obtain a judgment against employees for benefits already paid;
(3) employees might not seek needed medical treatment because they will be required to pay for it themselves; and
(4) a concern over the finality of judgments. Id.

In 2004, the Supreme Court decided the case of *Hickman v. Continental Baking Co.*, further sliding down the slippery slope of ignoring clear statutory language. *Hickman v. Continental Baking Co*., 143 S.W.3d 72 (Tenn. 2004). In *Hickman*, an injured employee received workers' compensation benefits and filed a third-party action. After a sizeable third-party recovery, the employee tried his workers' compensation claim and there was no lump sum settlement as there had been in *Graves*. The Supreme Court made an arbitrary, unprecedented, and non-statutory distinction between indemnity benefits and medical benefits, holding that, even where there is no lump sum settlement, the employer is entitled to a credit against future periodic indemnity benefits but *no* future credit as to future medical expenses. The Court used an illogical hypothesis to justify its decision:

Employees should not be placed in the difficult position of not being able to spend their workers' compensation benefits for fear that some or all of those benefits may have to be returned to the employer if needed medical treatment is sought. If the employee is unwilling or unable to pay the employer when the employer seeks reimbursement from the employee, the employer could obtain a judgment against the employee and presumably be in a position to collect that judgment on the employee's personal assets and whatever income stream the employee might have at the time. This situation is an untenable one that should be avoided. Id.

The Court further ignored the clear language of the Tennessee statute and judicially legislated a contrary outcome, based on the "difficult position" giving full effect might put employees in:

Employees will be placed in the difficult position of not being able to spend their third-party recoveries even if period payments are credited against the third-party recovery. Holding these funds hostage for an indefinite period of time is just as unacceptable under these circumstances as it was in Graves. As such, the logic underlying Graves compels us to reach a similar result in

this case. We therefore apply the holding of Graves to the present case and conclude that [the employer] is not entitled to a credit against future liability for medical expenses that are unknown or incalculable at the time of the trial of the workers' compensation case. Id.

In actual practice, carriers receiving a future credit simply stop making medical and indemnity payments and notify the health care providers to look to the employee for future medical care. This renders the logic underlying the *Graves* decision unsound.

After the *Graves* decision, the rule regarding future credits became that a carrier is not entitled to a credit toward future medical expenses that are "unknown or incalculable" at the time of the trial of the workers' compensation case. *Id*. This departure from the clear future credit language of the statute was countenanced in 2013 when the Tennessee Supreme Court doubled down on both the *Graves* and *Hickman* decisions.

Cooper v. Logistics Insight Corp.

In 2013, the Supreme Court decided the case of *Cooper v. Logistics Insight Corp.,* 2013 WL 163976 (Tenn. 2013). In *Cooper*, Joshua Cooper was seriously injured on the job, recovering $44,698.62 in workers' compensation benefits and filing a third-party suit, which he later settled for $190,000. When it came time to take its credit, Cooper argued that his employer should not be able to take a credit toward future medical benefits he had coming.

The *Cooper* decision recounted the history of future credits in Tennessee, specifically focusing on the unlimited medical benefits owed in modern claims compared to limited medical benefits owed when earlier decisions had been handed down. It also noted that the legislature had not acted on the issue since the *Graves* decision, stating that *"we see no compelling reason to reverse direction in the absence of legislative action."* The *Cooper* ruling was summarized as follows:

We therefore reaffirm our holdings in Graves and Hickman. [The employer's] subrogation lien against the proceeds of the settlement with the defendants in the chancery court action does not extend to the cost of future medical benefits to which [the claimant] may be entitled. Id.

Interestingly, the Court made no analysis and no comment as to whether Cooper's future medical expenses were "unknown or incalculable" as set forth in *Graves*. They did remand the case to the trial court for a determination of the amount of the employer's subrogation lien and for further proceedings.

Cooper v. Logistics Dissent

Justice Koch penned one of the most logical and well-substantiated dissents I have ever read. Astutely pointing out that the "mindless obedience to the Doctrine of *Stare Decisis* can confound the truth", the dissent felt that the Court should have departed from the questionable precedent of *Graves* and *Hickman*, stating:

In accordance with the plain meaning of Tenn. Code Ann. § 50-6-112(c)(2), (3), the credit to which an employer is entitled does not operate as a refund out of the employee's recovery. Rather, it negates an employer's responsibility to pay additional workers' compensation benefits until the employee's net recovery from the third party is exhausted or until the employer's obligation to pay workers' compensation benefits is exhausted. Consistent with this Court's decision in Reece v. York, an employee who obtains a recovery from a third party must use his or her "net recovery" to pay for future medical care relating to the injury until the net recovery is exhausted. An employer's liability for the medical expenses related to the employee's injury recommences only after the employee has exhausted his or her net recovery in paying for the necessary and reasonable medical expenses from the work-related injury. Id.

The dissent argued that a subrogated workers' compensation carrier is entitled to a lien on any third-party recovery. This lien includes both recovery of past benefits paid and a credit under § 50-6-112(c)(2) against *any* future benefits – indemnity or medical – without regard to the nature of the future medical benefits. The carrier can cease payment of medical and indemnity benefits until the employee's "net recovery" from the third party is exhausted or until the carrier's obligation to pay future benefits is

exhausted. “Net recovery” is “the total amount collected by the employee in the tort action [against the third party], less reasonable expenses, including attorneys’ fees.” *Cross v. Pan Am World Servs., Inc.,* 749 S.W.2d 29 (Tenn. 1987) (overruled on other grounds by *Summers v. Command Sys., Inc.,* 867 S.W.2d 312 (Tenn. 1993)). Employees must once again use their net recovery to pay for future medical care and the carrier’s obligation to pay for medical expenses recommences only after the employee has exhausted his net recovery in paying future reasonable and necessary medical expenses. It is no longer material whether future medical benefits are “unknown” or “incalculable” and no longer is a factual inquiry into the nature of future medical expenses required.

Justice Koch’s dissent did more than point out that the *Cooper* decision perpetuates 40 years of bad interpretation of § 50-6-112. It also suggested that both the carrier and employee should be able to take advantage of the reduced schedule of medical expenses paid by a workers’ compensation carrier. In other states, in order for the claimant to take advantage of the reduced medical fee schedules under which carriers pay medical benefits, thereby extending a future credit considerably, collusive arrangements involving the continued payment of medical by the carrier and periodic reimbursement by the claimant had to be entered into. The *Cooper* dissent observed that the cost of medical care provided pursuant to the Workers’ Compensation Law is governed by a fee schedule established by the Department of Labor and Workforce Development. Tenn. Code Ann. § 50-6-204(i). That schedule is applicable to “all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers’ Compensation Act.” Tenn. Comp. R. & Regs. 0800-02-17-.01(1) (2009). The dissent suggested that because medical care provided to an employee subject to the future credit is derived from the employee’s workers’ compensation claim and, it should be governed by this fee schedule, extending the carrier’s future credit significantly longer than if the future credit was reduced by the “wholesale” cost of medical expenses without the reduction under the fee schedule.

Modern Rule

Nonetheless, the rule in Tennessee regarding future credits remains the rule set forth in *Graves* and *Hickman*. The credit provided for in § 50-6-112 does *not* encompass future medical payments when the employer and employee settle the compensation claim for a lump sum award. *Id*. A carrier is not entitled to a credit toward future medical expenses that are “unknown or incalculable” at the time of the trial of the workers’ compensation case. *Id*.

If you have any questions regarding this article or subrogation in general, please contact Gary Wickert at **gwickert@mwl-law.com**.

HEALTH INSURANCE SUBROGATION

THE SMART ACT BECOMES LAW

Sanity Restored To Medicare Secondary Payer Liability

The 112th Congress had a lot on its plate – from the “fiscal cliff” to Hurricane Sandy relief. However, no matter your politics, Democrats and Republicans agree completely on one piece of legislation passed by Congress over the Christmas holiday. With only three “no” votes in the House and unanimous passage in the Senate, Congress passed H.R. 1845, including legislation known as the “Strengthening Medicare and Repaying Taxpayers Act” (SMART Act). The Act will improve the efficiency of the Medicare Secondary Payer (MSP) system and process, by requiring the Centers for Medicare and Medicaid Services (CMS) to streamline its process eliminating the uncertainty and costly delays in settling claims and providing funds to the beneficiaries sooner. President Obama signed the bill into law on January 10, 2013.

Clients and friends of Matthiesen, Wickert & Lehrer, S.C. may recall the 2010 article published by Gary Wickert in NASP *The Subrogator* entitled, *Subrogation and Medicare Set-Asides.* A copy of that article can be viewed **HERE**. It recounts in some detail the problems created in December 2007 when Congress enacted § 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), which required any entity making a payment to a Medicare beneficiary to report that payment to the CMS. Section 111 created a new enforcement tool for CMS to

pursue MSP claims through a new reporting requirement and a shift in compliance responsibilities upon the regulated community of group health plans, workers' compensation plans and insurers, liability insurers, self-insureds, and others. It became a tremendous pain in the derriere, complicating claims adjusting and subrogation practices, and holding up settlements in even small claims.

The SMART Act intended to effect major changes and provides more efficiency and certainty to the MSP process for non-group health plans, workers' compensation carriers, and primary payers. This means it is aimed squarely at Medicare liens and the potential liability to CMS which lingered when litigation, third-party actions, or workers' compensation claims were settled. A copy of the complete bill can be viewed **HERE**.

The Act effectuates changes important and beneficial to trial lawyers, their clients and primary payers, which is why the Act is universally applauded on both sides of the bar and the political aisle. Plaintiffs and their attorneys should benefit from a provision locking in the Conditional Payment amount for three months. Primary payers will benefit from safe harbor provisions for Responsible Reporting Entity (RRE) reporting.

Benefits To Primary Payers (Insurers)

One of the biggest obstacles for carriers and subrogated insurers was the overriding question as to whether an injured plaintiff or claimant was Medicare eligible – the lynchpin for all of the administrative nightmares previously associated with the MSP law. The CMS had created a Query System to determine whether individuals are Medicare eligible; however, that system has been reliant on Medicare numbers and Social Security Numbers (SSNs). It will be interesting to see if CMS can develop a workable system that avoids such personal information. The SMART Act will help primary payers by creating a "safe harbor" where the primary payer is unable to obtain the plaintiffs' SSNs *after a good faith effort*. This change was necessitated by plaintiffs' refusal to provide their Medicare numbers or SSNs due to privacy concerns. Medicare numbers are often just as "private" as SSNs because they are generally the SSN followed by a letter.

In addition to eliminating the use of SSNs and Medicare numbers, the SMART Act creates a three-year statute of limitation for all MSP claims. The new three-year statute of limitations for MSP recovery actions accrues from the date of receipt of the Section 111 report, which makes that date our new best friend.

Benefits To Plaintiffs

The passage of the SMART Act is also applauded by trial lawyers. The key benefit for plaintiffs and their attorneys is the new ability to "lock in" Conditional Payment amounts prior to settlement. If the Medicare Secondary Payer Recovery Contractor (MSPRC) is provided with enough time to calculate the Conditional Payments prior to settlement, and, if they are informed of the settlement less than three months after its determination of Conditional Payments, the MSPRC cannot increase that amount thereafter. In theory, this is good news, but it remains to be seen whether the MSPRC can comply with such a system. It is possible we could end up with even longer waiting periods for the initial Conditional Payment letter.

Nonetheless, this three month lock-in period should be well-received by plaintiff attorneys as it should take some of the guessing game out of MSP compliance. However, it is important to remember the SMART Act does not effect or create MSA rules. The SMART Act also requires CMS to set a monetary threshold under which the MSP rules will not apply – giving a green light once again to the typical smaller settlements involving personal injuries.

Benefits To Everyone

Under the new Act, CMS would have 65 days from the receipt of a request to provide the Medicare reimbursement amount, which can be extended 30 days after additional notice is provided to CMS with respect to a failure to respond to the initial request. After this period, the parties can rely on the reimbursement amount available on the CMS website.

Effective January 1, 2014, certain liability claims will be exempt from reporting and reimbursement if the claim falls below the annual threshold as calculated by the Secretary of Health and Human Services

(HHS). Civil penalties for non-compliance with mandatory insurance reporting requirements will now be discretionary and "up to" $1,000 for each day of non-compliance with respect to each claimant. CMS is also now mandated to implement a reporting process so that responsible reporting entities do not have to access or report SSNs or Health Identification Claim Numbers (HICN).

Other Benefits Of The SMART Act

The American Association of Justice (AAJ) has provided a nice section-by-section summary of some of the changes made by the SMART Act. CMS is required to maintain a secure web portal with access to claims and reimbursement information. The web portal must meet the following requirements:

- Payments for care made by CMS must be loaded into the portal within 15 days of the payment being made.
- The portal must provide supplier or provider names, diagnosis codes, dates of service, and Conditional Payment amounts.
- The portal must accurately identify that a claim or payment is related to a potential settlement, judgment, or award.
- The portal must provide a method for receipt of secure electronic communications from the beneficiary, counsel, or the applicable plan.

- Information transmitted from the portal must include an official time and date of transmission.
- The portal must allow parties to download a statement of reimbursement amounts.

The Reimbursement Process

The SMART Act requires parties to notify CMS when they reasonably anticipate settling a claim (any time beginning 120 days before the settlement date). CMS then has 65 days to ensure the portal is up to date with all of the appropriate claims data. CMS can have an additional 30 days on top of the 65 days to update the portal if necessary. At the expiration of the 65- and potentially the 30-day periods, the parties may download a final Conditional Payment amount from the website. The final Conditional Payment amount is reliable as long as the claim settles within three days of the download.

Resolution of Discrepancies

CMS is required to provide a timely process to resolve any discrepancies regarding the amount to be reimbursed. An individual can provide the Agency with documentation to establish that the web portal is not reflecting an accurate reimbursement amount. CMS is required to respond to this documentation within 11 business days. If CMS does not make a determination within 11 days, the reimbursement amount as calculated by the beneficiary becomes the final Conditional Payment amount.

Appeals

CMS must draft regulations that give applicable insurance plans limited appeal rights to challenge final Conditional Payment amounts. These appeal rights are only applicable in the event CMS attempts to collect reimbursement from the plan. Beneficiaries must be given notice of any appeal undertaken by an insurance plan. Existing appeal rights for beneficiaries remain the same.

Section 202 (Claims Threshold for Collection)

CMS, with input from the Government Accountability Office (GAO), is required to calculate and implement a threshold amount for liability claims (excluding ingestion, implantation, and exposure claims) only. The threshold amount will be based on the costs to CMS for collecting an average claim. If an amount owed is under that threshold amount, CMS is barred from seeking repayment. The threshold will be calculated and adjusted annually.

Section 203 (Reporting Requirements)

CMS has discretion in applying reporting penalties on insurance companies. Previously, any reporting error by an insurer was subject to a $1,000 a day penalty. The SMART Act amends the statute to allow for discretion in the amount of the penalty based on the severity of the violation.

Section 204 (Use of Social Security Numbers in MSP Reporting)

CMS is required to modify plan reporting requirements within 18 months so that plans do not have to use SSNs or Health Identification Claim Numbers (HICN). CMS may have an additional 12 months if it affirms to Congress it needs more time. This provision addresses several policy concerns related to privacy and reporting problems.

Section 205 (Statute of Limitations)

CMS only has three years from the time they are notified of a settlement to seek payment for medical services provided. This provision will eliminate a CMS push for a six-year statute of limitations that had recently been argued in the 11th Circuit.

Subrogation counsel should still be consulted on larger subrogation cases involving future medical and MSP issues. However, it sure is nice for a change when Congress realizes it has done something dumb and actually goes back and fixes the mistake. The SMART Act is estimated by the Congressional Budget Office (CBO) to save taxpayers $45 million over ten years.

If you have any questions regarding this article, subrogation in general, or need subrogation representation anywhere within North America, contact Gary Wickert at **gwickert@mwl-law.com**.

UPCOMING EVENTS

April 9, 2013 – Doug Lehrer and Tim Pagel will be presenting a teleconference on *Parental Liability For The Acts Of A Minor* for the National Business Institute (NBI). Information on this teleconference can be found **HERE**.

April 10, 2013 – Aaron Plamann will be presenting a seminar on *Product Liability Property Subrogation: A Litigating Engineer's Perspective* at the National Property Subrogation Strategies ExecuSummit in Uncasville, Connecticut. Information on this conference can be found by clicking **HERE**.

Information On Our Upcoming Webinar Will Be In Our February Newsletter