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BEWARE MEDICARE AND SCHIP

by Tony Patterson



When handling personal injury claims, plaintiffs' counsel often address the resolution of subrogation liens, including those asserted by Medicare. Under federal statutes, Medicare is entitled to reimbursement when an injured Medicare recipient receives benefits which are later recovered through a settlement or judgment. New legislation has now given Medicare an effective – and harsh – means of recovering its subrogation lien.

In 2007, the Medicare, Medicaid and SCHIP Extension Act (the "Act") was signed into law, placing new and more detailed requirements on liability insurance companies in claims dealing with Medicare recipients. This 2007 Amendment, effective July 1, 2009, is the counterpart to the 2003 Amendment,

which focused on plaintiffs and their attorneys. The 2007 Act increases the enforcement power for Medicare reimbursement by extending liability to insurers and adding damages, penalties, and fines for noncompliance.

If Medicare is not contacted early, the process of resolving these subrogation liens can be arduous and time consuming. Furthermore, failing to address a Medicare lien can result in substantial losses to plaintiffs' counsel and their clients due to penalties and fines. When Medicare has not been properly reimbursed, the Agency can recover reimbursements from any party that received proceeds from the settlement or award, including plaintiffs, attorneys, and insurers, *even if the insurer already paid the claim to the plaintiff.*

The Act affects plaintiffs in at least two ways. First, Medicare can recover from plaintiffs and their attorneys if the lien is not properly reimbursed, and additional penalties can be assessed. Second, insurers will now require proof of compliance with Medicare's lien before paying a plaintiff, as that insurer can be liable to Medicare if the plaintiff does not properly comply with the Act.

The 2007 Amendments provide, in part, that insurers are subject to a fine of \$1,000 per day for non-compliance for each individual with whom they are out of compliance. 42 U.S.C. § 1395 (2009). This fine is in addition to the interest and double damages that can be assessed for failure to reimburse Medicare in a timely manner. *Id.* In addition to these changes, in 2006 the Center for Medicare and Medicaid Services approved a single, national Medicare Secondary Payer Recovery Contractor (MSPRC) to handle all claims.

The effect of the Act is not limited to its affect on plaintiffs, their attorneys, and liability insurance companies. Medicare also can recover reimbursements from any involved party that received proceeds from a settlement, judgment, award, or other payment, including, but not limited to,

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LEGALLY SPEAKING



Paul Kruse

THE MYTH ABOUT FRIVOLOUS LAWSUITS

I recently responded to a newspaper editorial written under the headline: “Lawyers, Spurious Lawsuits Threaten a Potential Civic Disaster.” Many editors have fallen prey to the propaganda campaigns of insurance companies who try to poison the perception of the public – and potential jurors – about the impact of litigation on

our society. In fact, our homes, cars, products and lives are safer because personal injury lawyers hold manufacturers and others accountable for their misconduct, and with my letter I tried to set the record straight.

The U.S. Consumer Products Safety Commission reports there has been a 30% decline in the rate of deaths and injuries associated with consumer products over the past 30 years. The National Highway Traffic Safety Administration reports that the overall number of traffic fatalities on the nation’s highways in 2008 was the lowest since 1994, and the fatality rate per 100 million vehicle miles traveled declined to its lowest point in history. Thank trial lawyers for improvements in the safety of products and the design and maintenance of highways and vehicles, which are usually in response to, or to avoid, negligence claims for persons killed or injured.

Rather than focus on the positive changes that trial attorneys have brought about in our society, insurance companies and manufacturers would lead us to believe that the legal system is an impending civic disaster. They ignore the fact that every claim and verdict must survive the scrutiny and common sense of our judges and juries.

Trial attorneys are the only spokespersons for injured victims, and our only venue is the judicial system. That system, provided by our Constitution, has served us well for more than 200 years. It protects everyone, victims and alleged wrongdoers, from the misconduct of others. Go to our blog at www.Indianainjuryblog.com to read my letter to the editor – and pass the news!

BEWARE MEDICARE AND SCHIP (Continued from cover)

beneficiaries, attorneys, providers, and suppliers.

In calculating Medicare’s subrogation reimbursement, Medicare’s lien still can be reduced for a pro rata share of attorney fees and litigation expenses, known as “procurement costs”. Medicare’s portion of these “procurement costs” is deducted from the gross lien to determine Medicare’s net recovery. In addition, Medicare may agree to waive its lien, or a portion of it, in recognition of a plaintiff’s financial, personal, and medical circumstances.

When negotiating with Medicare, it is important to remember that while the Indiana Comparative Fault Act’s (Ind. Code § 34-51-2-19) lien reduction provision can reduce Medicaid liens,

Pedraza by Pedraza v. Grande, 712 N.E.2d 1007 (Ind. Ct. App. 1999); *In re Guardianship of Wade*, 711 N.E.2d 851 (Ind. Ct. App. 1999), it cannot reduce Medicare liens due to federal preemption. For this reason, plaintiffs’ counsel is forced to negotiate with Medicare under the terms allowed by federal rules discussed above.

In cases involving the need for post recovery treatment, plaintiffs’ net recoveries also may be reduced for future medical expenses anticipated to be paid by Medicare. Although based on a statutory provision in effect for more than 20 years (42 U.S.C. §§ 1395(y)(b)(2)(A)), Medicare has in the past four years begun requiring Medicare Set-Aside (MSA) arrangements

for future medical expenses in cases which involve worker’s compensation settlements. When a settlement pays for future medical expenses, Medicare may require a MSA arrangement funded with settlement proceeds to pay for future injury-related medical expenses covered by Medicare.

The new Medicare statute means it is more important than ever to immediately get on top of plaintiffs’ liens and subrogations. When handling a case involving a Medicare recipient, counsel should immediately notify Medicare, which can be notified by mail at MSPRC Liability, P.O. Box 33828, Detroit, MI 48232-5828. While the Medicare claims process may seem difficult, MSPRC’s website (www.msprc.info/) provides instructions for resolving Medicare liens, including flow charts of the claims process. In the end, waiting to notify Medicare until after the case is resolved likely will result in delaying the resolution of Plaintiffs’ claims. ■

Parr Richey Obremskey Frandsen & Patterson has attorneys who are experienced in handling personal injury claims involving Medicare liens. If you have questions, please contact our office toll-free at (888)532-7766.



RECENT COURT DECISIONS – HOW IT IMPACTS YOUR PRACTICE, YOUR CLIENT



UNBORN FETUS NOT A “CHILD” UNDER WRONGFUL DEATH STATUTE

In *Ramirez v. Wilson*, a semi-tractor collided head-on with a pregnant woman’s car. She was killed, and her daughter, S.R., died in utero. S.R.’s father filed a complaint for the wrongful death of the unborn child. The Court found that although S.R. was a viable, full-term fetus, under Indiana precedent, a fetus is not a child for purposes of the wrongful death statute and the driver was appropriately entitled to judgment as a matter of law on S.R.’s father’s claim for the unborn child’s wrongful death. *Ramirez v. Wilson*, 901 N.E.2d 1 (Ind. App. 2009).

Editor’s note: In response to *Ramirez*, legislation has been passed to include “a fetus that has attained viability” to the definition of “child”

as applied to Indiana’s *Wrongful Death* statute. I.C. § 34-23-2-1, effective July 1, 2009. ■

FORESEEABLE INJURIES INVALIDATE SUPERSEDING CAUSE DOCTRINE

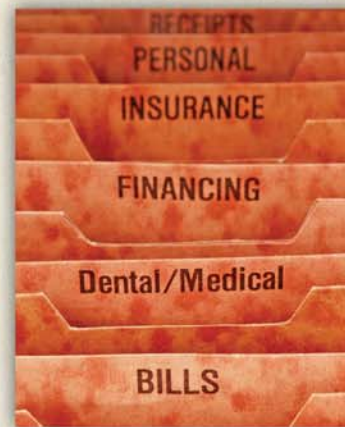
In *Franciose v. Jones*, a truck crashed into guardrails on an interstate highway. One of the truck’s passengers attempted to push the truck off the interstate and was hit by another automobile in the process. The passenger sued the original truck driver as well as the driver of the car that hit him. The jury awarded damages against both defendants. On appeal, the truck driver argued the jury verdict was untenable because of the superseding cause doctrine. The court initially noted that the superseding cause doctrine relieves a negligent actor from liability when there is a subse-



quent negligent act or omission so remote in time that it breaks the chain of causation. The Indiana Court of Appeals found that the facts in this case did not invoke the superseding cause doctrine because the jury could have determined the plaintiff’s injuries were foreseeable. *Franciose v. Jones*, 907 N.E.2d 139 (Ind. App. 2009). ■

EVIDENCE OF PATIENT’S SURVIVAL ODDS AND ABILITY TO WORK ADMISSIBLE IN MEDICAL MALPRACTICE CLAIM

In *Atterholt v. Herbst*, a patient died as a result of an improper diagnosis. His estate brought a wrongful death action against his medical providers, which was later settled at a level sufficient to allow the estate access to the Patient’s Compensation Fund. During the estate’s proceeding against the Fund, the court held that although negligence and causation is established once an underlying settlement is reached with a qualified healthcare provider, the Fund may introduce evidence of the claimant’s preexisting risk of harm, survival odds, and their ability to work if the evidence is relevant to establish the amount of the claimant’s damages. *Atterholt v. Herbst*, 902 N.E.2d 220 (Ind. 2009). ■



WRITTEN OFF MEDICAL BILLS NOT RECOVERABLE IN ADULT WRONGFUL DEATH ACTION

After a patient’s death, her estate in *Butler v. Indiana Dept. of Ins.* sought excess damages from the Indiana

Patient’s Compensation Fund. The Indiana Supreme Court held that, with respect to damages under Ind. Code § 34-23-1-2(c)(3)(A), the amount recoverable by the plaintiff in a wrongful death case for the “reasonable medical expenses” necessitated by the wrongful act is the portion of the billed charges ultimately accepted pursuant contractual adjustments, not the initial amount billed. The court reached its decision after analyzing the specific language contained in Ind. Code § 34-23-1-2, (the Adult Wrongful Death Statute). *Butler v. Indiana Dept. of Ins.*, 904 N.E.2d 198 (Ind. 2009). ■

DID YOU KNOW?

If a person entitled to bring a cause of action dies before the expiration of the time limitation for filing a claim, the decedent’s personal representative may bring the action anytime within 18 months after the person’s death. IND. CODE § 34-11-7-1 (previously § 34-1-2-7). This statute may extend the initial statute of limitations period, but does not serve to shorten the time limitation for filing a claim, regardless of when the death occurs.

— See *Bailey v. Martz*, 488 N.E.2d 716 (Ind. Ct. App. 1986).

EVIDENCE OF DISCOUNTED BILLS ADMISSIBLE TO DETERMINE "REASONABLE VALUE" OF MEDICAL SERVICES

In *Stanley v. Walker*, the two parties were involved in a car accident and the plaintiff filed a negligence complaint. The defendant asked the trial court to admit evidence that the plaintiff's healthcare providers discounted the medical bill. The plaintiff objected, arguing that any evidence of write offs would violate Indiana's collateral source statute, Ind. Code § 34-44-1-2. The Court discussed how, in Indiana, the proper measure of medical expenses is the reasonable value of such expenses. The court stated that this value is not based exclusively on the actual amount paid to the healthcare provider, or on the amount originally billed. The court thus held that the collateral source statute does not bar evidence of medical bills discounted by insurance providers in order to determine the reasonable value of medical services in calculating the plaintiff's damages. The court cautioned that this may only be done if the admission of the write offs can be done without violating the collateral source statute. *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009). ■

TYPE OF SERVICE	TOTAL BILLED
Medical Visit	
Testing X-ray Lab	
Surgery	
TOTAL THIS CLAIM	

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FIRM NEWS

\$2.2 MILLION MALPRACTICE VERDICT OBTAINED

A \$2.2 million damages verdict was obtained on behalf of a widower of a 68-year-old woman in Marion County. The case involved a woman with a history of a fatty liver requiring a liver transplant and leading to the development of heart disease. As a result of this condition, she underwent heart bypass surgery and valve replacement. While the surgery was a technical success, a surgical foam pad was inadvertently left inside the woman at the conclusion of the surgery. When the pad was discovered approximately a month later, it had become adherent to the heart and multiple perforations occurred when the pad was removed, resulting in a five-week-long, painful death from multi-system organ failure.

Initially, liability was contested as the hospital and

surgeon claimed the other was responsible for the pad's removal. After the decision of the medical review panel, liability was determined and the damages case was tried against the Patient's Compensation Fund. The primary dispute was over the value of the case, given the decedent's age of 68 and because she had a decreased life expectancy prior to the malpractice given her liver transplant, heart disease, and other conditions.

The case was tried in Marion County in June 2009 and damages were determined to be \$2.2 million. The Court reduced the damages to a cap verdict of \$1.25 million, consistent with the Indiana Medical Malpractice Act. The case was tried by Tony Patterson of Parr Richey Obremskey Frandsen & Patterson. ■

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