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Medicare Secondary Payer Act And Liability Cases

By: Renee Y. Little

What is the Medicare Secondary Payer Act?

Enacted in 1965, Medicare is the federal health insurance program for individuals over the age of sixty-five and individuals under age sixty-five with permanent disabilities. In the Omnibus Reconciliation Act of 1980 ("ORA") Congress enacted a series of provisions making Medicare the secondary payer when other groups, including auto, general liability, no-fault and accidental injury insurers, were available to assume primary responsibility. *Omnibus Reconciliation Act of 1980*, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (1980). Congress' intent was to shift costs assumed by the government through the Medicare program back to the primary payer, who Congress assumed was the party responsible for the injury. These provisions are known as the Medicare Secondary Payer Act (MSP) and are codified at 42 U.S.C. §1395y (b) (2) (A) (ii). This trend continued over the years with the goal of allocating primary coverage responsibilities to any and all other available insurance providers.

On December 29, 2007, President Bush signed the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"). Section 111 of the MMSEA requires all primary payers to identify and report to the Secretary of the Department of Health and Human Services (via the Centers for Medicare and Medicaid Services - "CMS") all Medicare beneficiaries to whom they have paid a settlement, judgment, award or any other payment. CMS is a part of the Department of Health and Human Services. It is the Federal agency responsible for the oversight of the Medicare program, including the implementation of Section 111 of the MSP reporting provisions.

Who has to Report?

The reporting obligation applies to all workers' compensation, liability and no-fault insurers, as well as all self-insured entities. These payers are identified as Responsible Reporting Entities ("RREs"). You are considered an RRE if you fund and pay, in whole or in part, a settlement, judgment award or make any other payment to a Medicare beneficiary. If you reimburse another entity that paid a settlement, judgment award or made some other payment, you are not considered an RRE, unless that reimbursement is to a third party administrator or results from a private settlement agreement. If you have a deductible plan and make payments directly to a Medicare beneficiary, you are an RRE. According to CMS, Third Party Administrators ("TPAs") are not RREs. They can, however, be designated as an agent permitted to report on behalf of the RRE, but the RRE cannot "contract away" its mandatory reporting liability.

Beginning January 1, 2010[1] insurance carriers and self-insured entities will be required to report all payments made above the reporting threshold to a Medicare beneficiary or Medicare eligible claimant/plaintiff. This means that all claims being handled by the insurers and self-insured must be checked to determine the Medicare status/eligibility of the claimant/plaintiff.

•What are the Mandatory Reporting Thresholds?

1. $5,000.00 for payments made on or after January 1, 2010
2. $2,000.00 for payments made on or after January 1, 2011
3. $600.00 for payments made on or after January 1, 2012
4. Note: there is no dollar threshold for payments made under a no-fault accident plan

What Information Does the RRE have to Report?

As noted above, RREs will be required to report all payments made on or after January 1, 2010 that exceed the reporting threshold. When mandatory reporting is

triggered by settlement, judgment, award or other payment, or any time prior to, the RRE must send an electronic query to Medicare. This query includes, but is not limited to, the claimant's social security number, date of birth, gender and name. Visit *www.Section111.cms.hhs.gov* for a complete listing of the data fields that must be completed when a report is made.

Once the initial payment is made for a Medicare beneficiary, subsequent reports will be required on a quarterly basis during the week specified by the CMS office.

When does the MSP Apply to Your Liability Case?

The MSP is applicable to your case if the claimant/plaintiff is a current Medicare beneficiary OR a potential Medicare beneficiary. If a claimant/plaintiff is a current Medicare beneficiary, they will have a Health Insurance Claim Number (HICN) and should be able to share that information with you.

A claimant/plaintiff is considered a "potential" Medicare beneficiary when they have a reasonable expectation of becoming a Medicare beneficiary within 30 months and the settlement amount is $250,000.00 or greater. A lot of confusion exists as to what is meant by a "reasonable expectation" that the claimant will be a Medicare recipient within 30 months. On April 22, 2003, the CMS issued a policy memoranda providing guidance on this issue as it concerns workers' compensation cases. In that memorandum, the CMS discussed what constitutes a "reasonable expectation." The CMS noted that a claimant may have a reasonable expectation when:

- The claimant has applied for SSDI (Social Security Disability Income);
- If applied and denied, the claimant anticipates an appeal;
- The claimant is in the process of appealing and/or refiling for Social Security Disability Benefits;
- The claimant is 62 1/2 years old or older (i.e., the claimant may be eligible for Medicare based upon age within 30 months); or
- The claimant has an end-stage renal disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

If the claimant/plaintiff satisfies both of these criteria (i.e., the settlement is greater than $250,000.00 and the claimant/plaintiff is reasonably expected to become a Medicare beneficiary within 30 months of the settlement date), then he or she is a potential Medicare beneficiary.

…all claims being handled by the insurers and self-insured must be checked to determine the Medicare status/eligibility of the claimant/plaintiff.

Practical Tips for Handling Liability Cases in the Wake of the MSP

Due to the reporting responsibilities that RREs must satisfy, claim-handlers and all attorneys must handle liability cases differently. Here, "differently" simply means enhancing and modifying the basic litigation tools that are used everyday. A few practical tips include:

- Adding interrogatories that mirror the characteristics of "potential" Medicare beneficiary (i.e., have you ever received Medicare benefits; have you ever applied for Social Security; have you ever been diagnosed and/or treated for end stage renal disease, etc.).
- In federal cases, create and identify the interrogatories noted above as "special interrogatories." In the scheduling order and/or at the scheduling conference, ask the Court to grant permission to issue the special interrogatories with the request that they not count against the limited number of interrogatories permitted under Rule 33 of the Federal Rules of Civil Procedure.
- Adding document requests instructing the plaintiff to produce copies of any and all correspondence they have had with Medicare/CMS; copies of any conditional payment documents, etc.
- In depositions, include questions aimed at identifying Medicare beneficiary and potential beneficiaries.
- For claims where suit has not been filed, have a questionnaire for the claimant to provide their HICN, state whether they have ever applied for Medicare or Social Security, disclose any diagnosis for end stage renal disease, etc.

Settlements Involving Medicare Beneficiaries

Medicare has a priority right of recovery for medical bills it has paid in the past and/or medical bills it might pay in the future on behalf of a claimant. Attorneys and parties to claims involving auto liability, accidental injury policies, general liability policy, self-insured entities, no-fault insurance or any other third-party payer, must watch out for Medicare's past and future interests or they risk running afoul of the CMS.

From a defense attorney's perspective, when attempting to settle a claim that involves a Medicare beneficiary or potential beneficiary, be sure to:

- Send correspondence to opposing counsel explaining the mutual obligations to identify and protect Medicare's lien during settlement negotiations.
- Make sure the claimant/plaintiff is advised of Section 111 mandatory reporting requirements, i.e., they are

aware that the RRE must and will report the full amount of the settlement to Medicare.

- Do not agree to settle or mediate without consideration of Medicare's interest.
- Require language in the release agreement explaining that Medicare's interest were properly considered, including the consideration of future medical needs where future treatment is required and/or anticipated.
- Make sure plaintiff's counsel approval of the release language with regard to Medicare's interest is demonstrated by counsel's signature.
- Recommend, in writing, the use of a Medicare Set Aside or Annuity where future medical treatment will be required and or is anticipated. If a Medicare Set-Aside or Annuity is used, make sure that these documents are exhibits to the release agreement.
- Discuss distribution of funds with opposing counsel, and confirm such in writing.

Settlement Involving Potential Medicare Beneficiaries

When settling a claim involving a potential Medicare beneficiary, consideration of Medicare's interest means consideration of whether any future medical treatment will be required. This is because, unlike the actual Medicare beneficiary, most potential beneficiaries don't have a Medicare lien as there were no payments previously made by Medicare.

Because the CMS requires the parties to "reasonably consider" Medicare's interests, talk with the claimant's attorney or claimant about voluntarily setting up a MSA and include it as part of the settlement agreement to cover future medical needs. This method provides an excellent format in which to demonstrate the consideration of Medicare's interests.

Recognizing that many claimants will refuse the voluntary establishment of a formal MSA, consider drafting a document similar to an MSA that anticipates future medical and prescription drug expenses, identifies funds intended to be set aside for those future expenses, and directs the claimant to spend those funds for future injury-related treatment only. At a minimum, add settlement language that specifically reflects the steps taken to reasonably consider Medicare's interests.

Are Medicare Set-Asides Mandatory?

No. CMS has not issued any memoranda regarding how to consider Medicare's interests in personal injury claims, they have indicated that they are not in a position, at this time, to review or offer advisory opinions in the form of verification letters that relate to the submission of an MSA for personal injury claims. CMS is working on an official statement concerning future medical expenses in personal injury claims. Until that statement is released, CMS has made clear that all parties are to "reasonably consider Medicare's interests" whenever the MSP is applicable. Although CMS approval is mandated for certain workers' compensation settlements, approval is not mandated for personal injury claims.

Even though they are not required, the MSA may be the best tool for demonstrating compliance.

RESOURCES

1. Original claim reporting date of July 1, 2009 has been changed to January 1, 2010. Centers for Medicare and Medicaid Services Alert (d: May 11, 2009). This alert also notes that the registration period for the RRE's has been extended until September 30, 2009.

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Failing Business Claims Threaten To Drown Professionals

By: Johannes S. Kingma

Introduction

Failing businesses have originated an increasing proportion of claims against professionals since 2007. While, these claims often assert the same cause of action as those which do not arise from a failing business, they routinely play out in bankruptcy court rather than state or federal district court. Even the parties may be different. This article will help you spot the issues which arise in failing business claims and will also discuss risk management for you, your clients, and your insureds.

The wave of failing businesses has not yet crested. United States bankruptcy filings in 2008 were twenty-five percent higher than bankruptcy filings in 2007[1]. Bankruptcy filings in the Northern District of Georgia for the first quarter of 2009 were sixty-one percent higher than in the first quarter of 2008[2]. Formerly respected financial service companies like Stanford Financial are being revealed as Ponzi schemes, and strong financial players such as CIT are apparently on the rocks without the hope of a federal bailout. The U.S. auto industry may not survive despite federal support, and commercial real estate continues to sink. Particular weakness in the banking industry continues to trouble all of us. In fact, just last month the Wall Street Journal called my home state, Georgia, the Chernobyl of banking. As of June, Georgia was home to twenty percent of the nation's bank failures in the last year. At that time regulators had already seized six Georgia banks, and by my count, seven more have been taken in the last month. The Wall Street Journal reports that an additional thirty banks in Georgia are at risk of failing. Needless to say, California, Florida, Illinois and Texas are also seeing an increase in bank failures.

The associated press reports that foreclosures were up eighteen percent in May, compared to May 2008, and are likely to remain elevated until at least 2010. Past experience suggests that claims usually follow business failures by a year or two. Given the current credit markets, falling property values, job losses, and declining retail sales, the insolvency wave may not crest until late 2009 and the resulting claims may not peak until 2010 or 2011. These business failures create increased risk for professionals. Those whose clients are centered in retail, financial, real estate, construction, or other hard hit industries would be wise to study the swell of the wave.

How Do Business Failures Change the Nature of the Risk?

A professional's relationship with her client is often a critical part of her risk management. Happy clients who have been treated well and who have relied upon your expertise for years are not likely to sue you even if something goes wrong. Even twenty years of good client relations, however, will do you no good if the plaintiff is a trustee in bankruptcy, receiver, the unsecured creditors committee, or a creditor's litigation trust.

Likewise, rising share prices help reduce the number of potential investor plaintiffs. When share prices are growing fifteen percent a year, there are few unhappy investors. In 2008, however, almost every investor was an unhappy investor and unhappy investors are much more likely to be plaintiffs.

Professionals are under unusual stress in a time of failing businesses. Directors and officers often have no viable choices and are faced with unsolvable problems while they try to keep business alive. Outside professionals such as accountants and attorneys are often asked to do the undoable (or the unthinkable) by a failing business. Accepting or denying undoable assignments yields to increased risk of claims. Professionals, whose income may have fallen as a result of failing clients, may dabble in areas in which they are unfamiliar or take risks they would not usually take, sometimes with catastrophic results. Professionals who are not getting paid or whose fees constitute a preferential payment may sue for fees. Like night follows the day, such suits often result in a counterclaim for professional negligence.

Outside professionals such as accountants and attorneys are often asked to do the undoable (or the unthinkable) by a failing business.

Financial fraud abounds in a time of failing business. Failing businesses often misrepresent their financial status in an effort to stay within their loan covenants. New Ponzi schemes arise as failing businesses attempt to cover their obligations with new investments. Old Ponzi schemes, which grew during the time of prosperity, are almost always revealed when the market turns down. Sarbanes-Oxley's section 307 requires lawyers to report material misrepresentations, material violations of security laws or breaches of fiduciary duty which may arise when a business is failing. Professionals also need to be alerted to the dangers of fraudulent conveyances. Principals of a failing business or the business itself may see the handwriting on the wall and attempt to protect assets from creditors and the bankruptcy trustee. Those seeking to preserve their assets will often utilize lawyers and accountants to aid them in what they call estate planning or asset protection. Such actions may subsequently be characterized as fraudulent conveyance. The professionals may find themselves sued for complicity in fraud under a racketeering or aiding and abetting theory.

Auditors must frequently sail between Scylla and Charybdis when their audit clients approach insolvency. GAAS requires auditors to conduct a going concern evaluation prior to issuing an opinion on a company's financial statement. If the evaluation reveals substantial doubt as to a client's ability to continue as a going concern for one year, the auditor must disclose that doubt in their opinion[3]. Businesses who are at risk of failing are typically desperately trying to raise new capital. Audited financial statements are often a critical element of such fund raising efforts. If, however, the auditor's opinion reflects substantial doubt that the company will continue in business for another year, the financial statements may be a death knell rather than a marketing tool. If, on the other hand, the auditor provides a clean opinion which does not raise the specter of going concern language, he may prove an attractive target to new investors who allegedly relied upon the financial statements.

Surety and Fidelity Claims

Professionals who work for solvent companies usually do not need to worry about claims from the surety. If, however, the business fails, a surety may be required to pay on their bond. The surety will immediately look to accountants, lawyers or anyone else upon whom they can claim to have relied in issuing the bond. This type of claim simply doesn't occur with solvent companies. Likewise, if there is no financial fraud, you need not worry about a fidelity bond issuer suing a professional. In the current environment, however, financial fraud is both more common and more frequently discovered. If a carrier pays out due to a fidelity bond, once again they are looking for accountants and other professionals who they claim should have prevented the loss.

Receivers

Receivers may be appointed by state or federal courts to collect and distribute the assets of a failed business. Receivers are typically experienced in suing professionals, and view such lawsuits as a part of their job description. Any goodwill that outside professionals have established

with the failed business is out the window when the receiver takes over. Likewise, the receiver is rarely concerned about his or her reputation in the industry in which the business operates, and does not worry about long-term relationships with professionals. All of these factors make receivers unusually aggressive plaintiffs.

The Federal Deposit Insurance Corporation typically works as a receiver when an FDIC-insured bank fails. The "good" assets and deposits of a bank are shifted to a solvent bank and the "bad" assets are kept by the FDIC. The FDIC has designated a special unit to sue directors, officers and professionals, and that unit is currently conducting depositions and interviews in preparation for what we expect to be a wave of new lawsuits. Just as in the 1980s, the FDIC as receiver stands ready to generate fees for defense lawyers and strike fear in the hearts of E&O and D&O carriers.

Bankruptcy

When a business goes into bankruptcy, the landscape changes significantly. Professionals who have performed work for the failed business are usually owed fees and must consider initially whether to file a proof of claim. Doing so can have unexpected consequences. If the proof of claim is filed, the professional may find himself trapped in bankruptcy court if the trustee or another creditor wishes to file a claim against him[4]. Defenses which appear strong in a federal district court may seem to lose their efficacy in bankruptcy court. Bankruptcy judges spend less time evaluating causation and liability defenses and more time distributing assets amongst creditors. Some defense lawyers believe that this makes bankruptcy court an unpleasant place for professionals who are defendants.

Defendants who are initially sued in a bankruptcy proceeding may wish to withdraw the reference and try to have their case heard in federal district court[5]. Defense counsel should carefully review the local rules, as sometimes that motion must be filed before an answer to the complaint is due. Those who think that the statute of limitations has barred any claim against them may be surprised to find that the statute has been extended two years from the order for relief[6].

Many surprised defendants have been trapped in a Bankruptcy Rule 2004 examination they even knew they were a target for a claim. Rule 2004 provides for almost unlimited deposition-like examinations which can ultimately be used as if they had been taken in a subsequent adversary proceeding. Professionals subpoenaed for 2004 examinations sometimes assume the examination is taken simply to help the trustee locate the assets of the estate. Anyone who is noticed for such an examination should check the bankruptcy docket carefully on PACER. Often they will find that a motion has been filed to retain special counsel to prosecute claims against professionals. The report of the trustee may also yield information which can help a professional understand his or her exposure as perceived by the trustee.

Deepening Insolvency

Perhaps the most reviled aspect of failing business claims is the theory of deepening insolvency. Essentially, a deepening insolvency claim alleges that an insolvent business and/or its investors and creditors were harmed when a business's existence was prolonged past insolvency, and that the professional was responsible for the "deepening." Some courts have found that deepening insolvency is a cause of action arising when a professional's acts caused the failing business to become even more insolvent than it already was[7]. Many commentators and defense lawyers have criticized this theory as essentially claiming that a defendant made a corpse more dead.

Some courts have found that deepening insolvency is not a cause of action, but instead a measure of damages[8]. Other courts have held that deepening insolvency is neither a cause of action nor a damage theory[9]. Some courts have ruled that deepening insolvency can only be based in fraud[10], while others have said it is supported by mere negligence[11]. All courts agree, however, that deepening insolvency is a creature of state law, and thus federal courts are bound by how they think the state courts would rule.

Conclusion

The swell of claims arising from failing businesses is likely to increase into 2010 and beyond. Failing businesses and the claims that arise from them may drown professionals who do not anticipate the swirling currents.

RESOURCES

1. www.uscourts.gov/bnkrpctystats/statistics.htm.
2. W. Yvonne Evans as quoted in the Fulton County Daily Report (May 13, 2009).
3. AU § 341.01 U.S. Auditing Standards issued by the American Institute of Certified Public Accountants.
4. 28 U.S.C. § 157(b)(2)(c).
5. 28 U.S.C. § 157(d).
6. 11 U.S.C. § 108.
7. E.g., Official Comm. of Unsecured Creditors VRF Lafferty & Co., Inc. 267 F.3d 340, 352 (3rd Cir. 2001).
8. E.g., Alberts v. Tuft (In re Greater Southeast Cmty. Hosp. Corp. I), 353 B.R. 324, 338 (Bankr. D.C. 2006).
9. E.g., Wheland Foundry, LLC v. Metal Techs., Inc. (In re Wheland Foundry, LLC), Adversary No. 08-1037, 2008 WL 2952483 (Bankr. E.D. Tenn. July 29, 2008).
10. Seitz v. Detweiler, Hershey & Asoocs., P.C. (In re CitX Corp), 448 F.3d. 672 (3rd Cir. 2006).
11. Smith v. Arthur Andersen, LLP, 421 F.3d. 989, 995 (9th Cir. 2005).

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MEDICAL PROVIDERS - IS YOUR ORGANIZATION RAC (RECOVERY AUDIT CONTRACTOR) READY?

By: Tonya F. Stokes

Is your organization a medical provider which receives medical payments from Medicare for patient services[1]? Watch out! The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, recently established a new recovery audit services program to audit Medicare payments. Under Section 302 of the Tax Relief Act and Healthcare Act of 2006, CMS created RACs, or Recovery Audit Contractors, to audit Medicare payments to medical providers to determine whether overpayments or underpayments have occurred[2].

Each RAC selected by CMS will implement a recovery audit services program on a regional basis. The goal of the program is simple - To reduce improper Medicare payments to medical providers. Under the Tax Relief Act and Healthcare Act of 2006, each RAC is responsible for doing three things: (1) identifying overpayments and underpayments by medical providers; (2) correcting past improper payments; and (3) implementing actions that will prevent future improper payments[3]. The multi-state pilot program authorized under Section 306 of the Medicare Modernization Act was hugely successful, resulting in over $1.03 billion in improper payments returned to Medicare[4]. As a result, the RAC program will be rolled out nationwide and will become permanent in all 50 states by 2010.

Why is the RAC program important? There are numerous reasons. First, if your organization bills Medicare for any fee-for-service program, your claims could be audited by a RAC. Second, the recovery audit services program allows RAC to audit your organization for Medicare payments going back three years, up to October 1, 2007. For claims paid after October 1, 2007, a RAC will be able to audit the claim up to three years after the claim is made. A RAC can also audit your organization in a current fiscal year. Third, and perhaps most important, allegations of fraud or Medicare abuse could be lodged against your organization as a result of any significant findings by a RAC.

Under Section 306 of the Medicare Modernization Act and Section 302 of the Tax Relief Act and Healthcare Act of 2006, each RAC will be paid on a contingency fee basis. Since RACs will receive a percentage of the improper overpayments and underpayments they collect from medical providers which receive Medicare payments, there is a strong incentive for auditing to occur. Connolly Consulting Associates, Inc. of Wilton has been selected as the RAC for the southeastern and south-central United States, known as Region C, which includes Georgia and South Carolina. In Georgia, the recovery audit services program began on August 1, 2009. The program is slated to begin in South Carolina anytime on or after August 1, 2009, as well.

A RAC audit is a complicated process, which utilizes numerous Medicare policies and CMS regulations and manuals. This article is meant only to provide a brief introduction to the RAC audit process. In a nutshell, this is how RAC audits work. Each RAC is required to employ medically trained personnel to perform audits, including nurses, therapists, certified coders, and a physician that serves as a medical director. To begin an audit, a RAC must show "good cause" to conduct a review of an organization's past Medicare claims[5]. Good cause is shown where there is new and material evidence that was not available or known at the time of the initial determination or decision regarding the medical payment and such evidence may result in a different conclusion; or where evidence shows that an obvious error was made at the time of the determination or decision of the medical payment[6]. Typically, a RAC is looking for payments for incorrect amounts, non-covered services, incorrectly coded services, and duplicate services. The RAC will make its determination based on whether the medical service provided was deemed "reasonable and necessary" for diagnosis and treatment, and whether the medical service was delivered in a proper setting under Medicare policies and CMS regulations and manuals.

The RAC audit can be a simple, automated process where no medical records are reviewed, or it can be complex, involving a medical record review by the medical personnel employed by the RAC. Using Medicare policies as defined under the Code of Federal Regulations and the CMS regulations and manuals, the RAC determines whether a medical provider over billed or under billed Medicare for its fee-for-service claims for the immediate three year period dating back no earlier than October 1, 2007[7]. If an underpayment is found, then written notice will be provided to the organization and reimbursement can be made. However, if an overpayment is found, written notice is provided to the medical provider and a demand letter is issued to collect the overage. If the organization agrees with the RAC's audit determination, then the organization can make arrangements with the RAC to make overage payments, including through recoupment[8]. However, if the organization disagrees with the RAC's audit, then the organization can contact the RAC to discuss the outcome of the audit. If a disagreement remains, then the organization can appeal the RAC's decision.

It is important to note that an appeal of a RAC's audit findings involve strict time lines and may involve several appeal stages including complex legal proceedings. The appeal process may require hearings before the administrative law tribunals, such as the Office of Medicare Hearings and Appeals and the Medicare Appeals Counsel, and an appropriate federal district

court. Such appeals, if undertaken, should not be treated lightly but should involve the assistance of skilled legal counsel.

So what can a medical provider do to prepare for the RACs? CMS recommends several things including:

- •Identifying where improper payments have been persistent by reviewing the RAC's web-sites and identifying any patterns of denied claims within their own practice or facility[9];
- •Implementing procedures to promptly respond to RAC requests for medical records;
- •Determining what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future.

A medical provider can also prepare for a RAC audit by creating an organizational process for addressing RAC requests and determining a process for handling appeals of a RAC audit. Such a process should also include selection of a law firm to handle the appeal process and setting aside funds for the expenses of an appeal process, as costs resulting from a RAC audit are unlikely to be covered by a medical provider's malpractice insurance policy.

RESOURCES

1. Medicare payments are defined by Part A or B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et. seq.
2. The Tax Relief Act and Healthcare Act of 2006, Pub. L. No. 109-432, 2006 HR 6111.
3. *See* the Health and Human Services Centers for Medicare and Medicaid Services website at www.cms.hhs.gov/RAC.
4. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 2003 HR 1.
5. *See* 42 C.F.R. § 405.986.
6. *Id.* at (a).
7. *See* 42 U.S.C. § 1395 ddd.
8. *See* 42 CFR § 405.370.
9. CMS recommends reviewing Office of Inspector General (OIG) and Comprehensive Error Rate Testing (CERT) reports at the websites www.oig.hhs.gov/reports.html and www.cms.hhs.gov/cert.

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PREPARING TO MEDIATE A THORNY CASE

By: Renee Y. Little

Unfortunately, many trucking and commercial vehicle accidents result in catastrophic injury and/or death. Due to the nature of these accidents, many cases fall into the category of what I call a thorny case – cases where more than identifying the driver at fault is at stake. Thorny cases are those that involve brain injuries, paralyzing injuries, drugs, alcohol, a deceased commercial driver, etc.

Despite the strengths of any case, there is always some probability that the plaintiff could win. For this reason, consideration is often given to mediation. More often than not, insurance companies want to engage in mediation to limit their risks in thorny cases. This article offers a few helpful tips to consider when developing a mediation strategy for a thorny case.

I. Preparation is Key

Previous proper preparation prevents poor performance. When preparing for mediation, you should prepare the case with the same mindset as if you were going to trial. You should be aware of the good points as well as the bad points of your case. This requires that you have knowledge of the cause of action(s) against your client(s), the theory of your case, and case law impacting important factual and evidentiary issues in your case. You should have sufficient information to establish an assessment of outcome ranges and the likelihood of prevailing. Simply stated, you should have a vast command of the facts and law so that you will be able to negotiate from a position of strength. Importantly, proper preparation will help make your client feel confident that he or she is positioned to get the best settlement. Know your case.

Be sure that you have all of the necessary documents that you are going to need in order to be persuasive at the mediation. If there are witnesses that have knowledge favorable to your position, make sure you have their depositions or an affidavit and bring it with you to the mediation.

II. Pick the Right Time to Mediate

Mediating at the right time can prove critical. Best practices counsels in favor of waiting until meaningful discovery has been completed. Thorny cases often require significant development of economic analysis of future care considerations, medical expert consultation, event reconstruction, toxicology experts, and time for the completion of special law enforcement investigations when such are conducted. Simply stated, the resolution of thorny cases will require knowledge of facts, arguments and related law in detail.

Take the time to learn all the good and bad stuff you should know about your case. It is essential that you bring with you all of the ammunition that you can muster in order to persuade the other side. Conduct the necessary discovery so that you will have an opportunity to make an intelligent and informed evaluation of the claim.

Courts will sometimes send parties to mediation before a case is ready to settle. If so, counsel should try to use the mediation as an opportunity to exchange information

and discuss the case with opposing counsel, streamline discovery, and set the stage for future negotiation and settlement.

III. Pick the Right Mediator

For difficult cases, a mediator with expertise in handling the case at hand could prove invaluable. Similarly, a trained and experienced mediator is equally important. The goal is to identify a mediator that is well trained and qualified to handle a thorny case. There are those times when it could also prove beneficial to select a mediator that is familiar to the attorneys involved in the claim or lawsuit, and who is above all else, trusted by the attorneys involved. The right mediator is the one that satisfies the specific characteristics necessary for the resolution of your case.

Thorny cases are those that involve brain injuries, paralyzing injuries, drugs, alcohol, a deceased commercial driver etc.

In thorny cases, however, there are some common characteristics repeatedly found in the "right" mediator. Often, the right mediator has a strong personality and is effective in dealing with difficult cases and difficult parties. He/she is a lawyer, has experience in handling similar cases, has knowledge of the law involved in your case, is as much of a facilitator as an evaluator, patient and unbiased.

At times, you may be unable to participate in the selection of your mediator. When this occurs, talk to your peers to find out what information they may have about the mediator's qualifications and methods.

IV. Prior to Mediation – Notify the Opposing Side of All Conditions to Settlement in Writing

Do not wait until the day of mediation to notify opposing counsel of any and all conditions to settlement. Send a letter to opposing counsel identifying any contingencies. The letter doesn't have to be long, but at a minimum, it should include the following:

- Thank you for agreeing to participate in mediation;
- The conditions to settlement, such as indemnification (including indemnification for defendants' own alleged negligence); plaintiff claimant's handlings of any and all liens and expenses; release of any related consortium spousal claims (not filed with the action being mediated); etc.
- An outline of any confidentiality requirements
- Time-frame for dismissal of the lawsuit (if filed)
- Identify time factor for payment distribution (if your client will require 30 days to issue the settlement check, inform counsel of that fact)
- A request that opposing counsel notify you of any conditions to settlement, plans to add new claims (such as a loss of consortium action) that they will also seek to resolve at mediation, and any other surprises that could impede settlement (or impact the authority considerations being give by your insurer/ self-insured)

In addition to the above, make sure to give attention to the resolution of any liens and/or subrogation claims, especially any Medicare Liens or Set-Asides that must be considered. Make sure to ask opposing counsel to discuss any Medicare Set-Aside, ERISA or other government repayment issues with his/her client prior to the mediation. Opposing counsel's failure to do so could thwart or stall settlement negotiations.

V. Prepare Your Client(s) for Mediation

Undoubtedly, as you are preparing to go the mediation, you've kept your client apprised of the factual and legal developments in your case. Despite your client updates, it is still necessary to realistically address the strengths and weaknesses of the case, including the risk of the failure to settle and costs associated with preparing the case for trial. This often involves meeting with your primary and excess insurers, as well as the insured(s), to establish and communicate the strategy that your team will employ at mediation.

Establish the importance of the insured(s) attending mediation. If your case involves volatile issues or parties, talk with your insured and your insurer about those issues. Take the time to explain the mediation process to your insured and your insurer (if you have a file handler that is new to mediation). Be sure to explain the role that you will play as counsel, the role of the mediator and any other persons that may attend (e.g., structured settlement broker, etc.). Talk with your client about the manner in which they are expected to behave during the mediation. Discuss the necessity of composure and respect during the mediation. Make sure that your client understands that they will have the opportunity to discuss any concerns, frustrations or comments that they may have during your private caucuses. Perhaps most importantly, explain to your insured that they must be patient. The goal of mediation is to get the case resolved and mediation could be an all day event.

Avoid surprises at mediation. Regardless of how strong you believe your defenses may be, talk realistically about any and all issues that impact the value of the case. This requires you to give significant consideration to

- Facts that could influence punitive damages
- Policy limit issues
- Future medical expenses or treatment costs
- Liberal venue verdicts, particularly recent verdicts that have been highly publicized
- Recent case decisions that

impact the evidentiary issues in your case
•Issues involving actual or potential violations of Federal Motor Carrier Safety Regulations that could serve as the basis for a claim of negligence per se

As an example, consider the case where the plaintiff suffered a soft tissue back injury, but the defendant driver tested positive for illegal drugs post-accident. While medical expenses and lost wages total $50,000.00, your client could be exposed to damages in excess of $500,000.00 or policy limits due to the presence of unfavourable toxicology results which are likely to be deemed admissible at the trial of the case. This possibility should be discussed and factored into the evaluation of the case, and particularly the level of settlement authority brought to mediation.

Keep in mind, your client wants your honest assessment of the strengths, weaknesses and unknowns. When preparing for mediation, your client will appreciate your candor and honesty because it will put them in the position to fairly evaluate the risks, assess the case for mediation, and obtain settlement authority that appreciates the issues presented in the case.

While cases with lesser exposure can generally be resolved with the insurer attending by phone, in thorny cases, it is important to make sure that individuals with full settlement authority will be present in person.

VI. Prepare a Concise Mediation Statement for the Mediator

The primary purpose of a mediation statement is to educate the mediator about your case. It is your opportunity to identify the strengths of your case, weaknesses known by your opponent, and discuss evidentiary issues that will be important to the mediation. Specifically, mediators have indicated that the issues most important to their understanding of a case include:

•Request that the statement remain confidential and not be shared with opposing counsel (if such is desired)
•Strengths of your case
•Weaknesses known by your opponent
•Pending discovery or dispositive motions
•Prior settlement demands and or offers
•Identification of any pending related criminal charges or ongoing law enforcement investigation
•Conditions to settlement
•Identification of any issues that may produce high emotion or volatile responses
•Copies of key documents, such as accident reports, important medical records, deposition testimony, photographs, etc. that counsel intends to rely on at mediation

I also recommend a face-to-face discussion with the mediator in advance of the mediation. This will allow you to identify any questions that the mediator may have and ensure that he/she understands your position in the case.

VII. Effective Use of Opening Statements

Mediation provides defendants with the forum to set the tone for an effective mediation. On the defendant's side of the "v," there are a couple of key points to keep in mind - compassion, composure and brevity.

Compassion and Composure

Sincere compassion and courtesy can go a long way. Often, mediation is the first time that both parties have met and had the chance to speak to each other. It is usually the first time that the insurer has had an opportunity to speak face-to-face with the plaintiff. Take the time to acknowledge that an event occurred and say that you're sorry that the plaintiff experienced the accident. This (or some similar) showing of compassion does not weaken your case – it shows that you and your clients' are human. After this is done, you can explain (in a non-threatening manner) the defendant's position in the case. Even when opposing counsel and/or their client has been unprofessional or disrespectful, remain composed and respectful.

Brevity

It is important to talk to the plaintiff (and his/her attorney) directly and not direct your opening statement solely to the mediator. First, thank the plaintiff for taking the time out to attend the mediation. Second, express your interest in settling the case. Third, talk about the facts from a position of strength. In doing so, you should take the opportunity to demonstrate the weaknesses of your opponent's case and highlight the strengths of your case. You want to show that you are prepared for mediation and trial if necessary. A prepared attorney is able to acknowledge any weaknesses and tell how they will deal with them in the defense of the case. Show confidence, but steer clear of appearing arrogant or self-righteous. This is not the time to argue your entire case. You'll have time to discuss more of your case with the mediator in caucus.

VIII. Get All Settlement Terms in Writing

Make sure you get all of the settlement terms in writing. Recognizing that a formal agreement is forthcoming, get all critical terms and conditions in writing and have the plaintiff and counsel sign the draft document. This is where your pre-mediation letter, discussed above, could come in handy. If all of your terms were accepted, you could ask that the parties sign that letter as it outlines all of your conditions, and add any other terms or conditions that were discussed and accepted at the mediation.

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FIRM ANNOUNCEMENTS

JOE KINGMA APPOINTED TO TWO LEADERSHIP POSITIONS WITHIN THE ABA

Joe Kingma has been appointed as the Tort Trial & Insurance Practice Section (TIPS) Liaison to the ABA Standing Committee on Lawyers' Professional Liability, and a member of the Ethics and Professionalism Special Standing Committee within TIPS for the 2009-2010 fiscal year. TIPS has 37,000 members nationwide, and is the source of knowledge and leadership on trial practice and critical issues of justice that involve tort and insurance law.

DAVID OVERSTREET APPOINTED TO PLUS COMMITTEE

David Overstreet, of the Charleston office has recently been appointed to the 2009-2010 Steering Committee of the Southeastern Chapter of PLUS (Professional Liability Underwriting Society). PLUS is a nonprofit organization with 6,000 members that was established to support and enrich the careers of people involved in the field of professional liability underwriting.

ERIC FRISCH APPOPINTED TO DRI PLANNING COMMITTEE

Eric Frisch has been appointed to the planning committee for the 2010 DRI Damages Seminar to be held next Spring. For more information on this event please visit www.dri.org.

CARLOCK COPELAND ATTORNEYS TO WRITE TIPS PROFESSIONAL MALPRACTICE SURVEY ARTICLE

John Rogers will serve as the general editor for an annual professional malpractice survey article to be published in the winter 2009 issue of the Tort Trial and Insurance Practice (TIPS) Law Journal. Broderick Harrell will contribute to the section on architects and engineers, and Lindsey Hettinger will contribute to the section on accountants.

RECENT VICTORIES

Defense Verdict in Nursing Home Attending Malpractice Case

On August 25, 2009 Dan McGrew and Kim Ruder obtained a defense verdict in a medical malpractice case against a nursing home attending physician in Upson County. Plaintiffs alleged that the attending physician failed to properly care for his elderly patient's decubitus ulcers. Plaintiffs contended that improper wound care allowed the decubitus ulcers to deteriorate and become infected, resulting in overwhelming sepsis and death. Plaintiffs further contended that the physician violated the standard of care in not inserting a feeding tube in the patient during her final months of life.

The jury found in favor of the nursing home attending physician on the basis that the evidence demonstrated that the nursing home patient suffered from advanced multi-infarct dementia and end-stage Alzheimer's disease, which had progressed to a terminal stage at the time of the patient's death. The evidence further demonstrated that the actual cause of death was an overwhelming urinary tract infection that led to the sepsis, as opposed to infected decubitus ulcers. After deliberating less that five minutes, the jury found that the nursing home attending's care over a six year period complied with the standard of care.

Summary Judgment Granted for Law Firm In Suit Arising from Commercial Real Estate Deal

Michele Jones and Joe Kingma represented a law firm that had closed the sale of a 342-acre tract in north Georgia. The purchaser, who had planned to create a large residential development, learned that an industrial waste landfill had been concealed on the property and sued the seller. The seller third-partied in Michele and Joe's client claiming that an escrow agreement and closing instructions had been violated. The purchaser's and the seller's cross-summary judgment motions were denied, but the law firm's motion, including a claim for indemnification from the seller, was granted. The seller has appealed, so stay tuned.

Dismissal of Case Against Insurer for Uninsured Motorist Benefits

Fred Valz and Erica Parsons defended an insurer who had issued a policy of auto liability insurance and an excess liability policy. The insurer was served with a lawsuit as a purported uninsured motorist carrier. The excess insurance policy, issued in North Carolina, had liability limits of $1 Million but did not provide uninsured motorist benefits. The insurer tendered the limits under the liability policy but failed to timely respond to certain Requests for Admissions seeking affirmation of coverage for uninsured motorist benefits under the excess policy and such requests were deemed admitted. Additionally, the named defendant failed to answer and default judgment was entered against him in the amount of $854,727.04. Fred and Erica moved to set aside the admissions and Plaintiff moved to impose sanctions against the insurer for failure to respond to discovery.

After extensive briefings and oral argument, the court granted the insurer's Motion to Set Aside Admissions and denied the Motion for Sanctions. Because the admissions were withdrawn, the Plaintiff could not obtain any further recovery under the policy, and he dismissed his claims against the insurer.

Supreme Court Victory in Bad Faith Case

Dave Root and Cheryl Shaw won an unanimous decision in the Georgia Supreme Court on behalf of an insurer accused of bad faith failure to contribute to a settlement. The insured was sued for wrongful death and its carrier refused to pay as much as the insured wanted it to pay at mediation. The carrier offered $200,000, but would not offer more, citing what it believed were viable liability

defenses of the insured. The insured thus contributed its own funds to the settlement, and sought to recover approximately $750,000 from its carrier on a bad faith theory. The Supreme Court held that an excess judgment was a prerequisite to the claim, and denied the insured's claim. Trinity Outdoor, LLC v. Central Mutual Insurance Company, ___ Ga. ___ (S09Q0605, decided June 1, 2009).

Directed Verdict on ADA Claim

On June 1-5, 2009, Adam Appel and Marquetta Bryan represented a public entity in an ADA discrimination trial in Federal Court in Augusta, GA. The Plaintiff, the former CEO of a Mental Health, Mental Retardation and Substance Abuse Center, alleged among other things, that his employer terminated him because of an impairment, Alcoholism, in violation of the American's With Disabilities Act. The eight member board terminated its CEO while he was on leave seeking in patient treatment for his alcoholism. The plaintiff presented evidence at trial that he was a "high functioning" alcoholic, but claimed that the Board members "regarded him as disabled" under the ADA based on his leave request and that after he requested medical leave for his alcoholism, the board decided to terminate him. While the 8 member board did terminate the CEO during his leave, the Board presented evidence that the termination was for reasons unrelated to the CEO's alcoholism. The Board also presented evidence that it did not regard the CEO as being disabled from his job, but simply that his job performance was putting the Center's funding in jeopardy. Five of the Board members testified during the 5 day trial. The former CEO also sued the public agency for breach of contract, which claim was defended by the agency's personal counsel. After the close of all evidence, the federal court judge granted the public agency's Rule 50 Motion for Judgment as a Matter of Law on the ADA claim only, which is the only claim Mr. Appel and Mrs. Bryan defended at trial. The Plaintiff's last demand prior to trial was for $665,000 and a "public apology" by the board. The jury did return a verdict of $202,000 against the Board on the breach of contract claim.

Defense Verdict in Plastic Surgery Malpractice Case

On May 6, 2009, lead counsel, Ashley Sexton, together with Wade Copeland obtained a defense verdict in a plastic surgery malpractice case in Fulton County. Plaintiff alleged that the defendant surgeon negligently performed a breast lift and augmentation. She contended that the size of implants used and the technique used to lift the breasts breached the standard of care and resulted in rippling around the areola, unsuccessful lift and an otherwise poor result. The trial judge, over objection, allowed evidence of the surgeon's subsequent, unrelated license suspension. Nevertheless, the jury found in favor of the plastic surgeon on the basis that the procedures performed and their attendant risks were explicitly discussed with, and consented to, by the Plaintiff. The jury also found that the surgeon's plan and execution of that plan were within the standard of care.

Complaint Against Accountant Dismissed

John Rogers defended a CPA on a complaint filed with the State Board of Accountancy. The taxpayer claimed John's client failed to tell her she would have to file a California tax return to report income from the sale of some commercial property out in California. John's response showed the taxpayer's claim was not believable. Contemporaneous notes indicated that the CPA had discussed the California filing requirement. Furthermore, California law allows taxpayers to appeal penalties, and the taxpayer never appealed. If she and her new accountant really believed John's client was at fault, they would have asked him to admit wrongdoing as part of an appeal to the California Franchise Tax Board. Two weeks after receiving John's response, the Enforcement Committee of the State Board dismissed the complaint.

Summary Judgment In Favor Of Insurer Affirmed On Appeal

Fred Valz and Erica Parsons defended a homeowners' insurer against claims for coverage for an accident that occurred away from the insured premises. The parents of a teenage girl were hosting her birthday party at a field belonging to family friends where guests could ride four-wheelers and engage in other outdoor activities. The teenager and her friend were seriously injured when the four-wheeler they were riding turned over. The parents sought coverage for the injuries under their homeowners' policy of insurance, contending that the field, located several miles from the insured premises, was being used "in connection with the insured premises." In affirming summary judgment in favor of the insurer, the Court of Appeals rejected this argument, explaining that adoption of such an expansive definition of "insured premises" would expose insurers to virtually endless liability.

SPEAKING ENGAGEMENTS

- Joe Kingma will be speaking on the preparation and examination of expert witnesses at the "Keep it Short And Simple…and Other Trial Tips" ICLE seminar at the Georgia State Bar on Friday, October 2, 2009.

- Lynn Olmert will be speaking on catastrophic injuries at the ICLE Workers' Compensation Law Institute put on by the State Bar Workers' Compensation Seminar on St. Simon's Island on October 15-17, 2009.

- Joe Kingma will be presenting "Building a Solid Foundation," a program on risk management & prevention, in Mobile, AL on October 2; Atlanta, GA on November 19; and Birmingham, AL on November 20.

- Eric Frisch recently spoke at the Georgia Defense Lawyers Association Deposition Boot Camp on the basics and preparation of a deposition outline.

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CIVIL LITIGATION

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