

REASONABLE AND RECOVERABLE MEDICAL EXPENSES

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March 8, 2014

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I. INTRODUCTION

There is another medical insurance crisis in Texas, but this one has nothing to do with medical malpractice and tort reform. Instead, as a result of the Texas Legislature's actions with respect to "paid or incurred" and reductions in payments to doctors and hospitals, both by the government and private health care insurers, plaintiffs, lawyers, and medical care providers are looking for ways to avoid these limitations so as to increase the amount of money that can be recovered. They are getting creative.

As the Texas Supreme Court noted in *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2012):

Charges for health care, once based on the provider's costs and profit margin, have more recently been driven by government regulation and negotiations with private insurers. A two-tiered structure has evolved: "list" or "full" rates sometimes charged to uninsured patients, but frequently uncollected, and reimbursement rates for patients covered by government and private insurance. We recently observed that "[f]ew patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates." Hospitals, like health care providers in general, "feel financial pressure to set their 'full charges'...as high as possible, because the higher the 'full charge' the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital's 'full charge.'"

Although reimbursement rates have been determined to be reasonable under Medicare or other programs, or have been reached by agreements between willing providers and willing insurers, providers nevertheless maintain that list rates are also reasonable. Providers commonly bill insured patients at list rates, with reductions to reimbursement rates shown separately as adjustments or credits.

Id. at 393-94 (citations and footnotes omitted).

This paper will address the inherent conflict between the collateral source rule and the "paid or incurred" rule. A brief review of Section 41.0105 and the current state of the law with respect to that provision will be provided.

This paper contains an analysis of Chapter 146 of the Texas Civil Practice and Remedies Code and its potential impact on hospital liens and recoverable medical expenses. Health care providers ignore this statute at their own peril.

The paper contains a review of the law as it stands today in Texas with respect to the games being played to increase damage recoveries.

Additionally, this paper takes a look at the issues surrounding Medicare and its status as a secondary payor. Are there arguments that can be made that were not otherwise addressed or disposed of by the court in *Speegle v. Harris Methodist Health Sys.*, 303 S.W.3d 32 (Tex. App.—Fort Worth 2009, pet. denied)? Maybe. This will be an important issue as the Medicare rolls explode.

Finally, this paper will take a look at possible avenues to be explored by defendants and their carriers. Is there a duty to mitigate argument to be made with respect to medical expenses and health insurance? What information might defense counsel want to obtain in discovery? Does the Legislature need to get involved again?

II. PAID OR INCURRED

Section 41.0105 of the Civil Practice and Remedies Code provides:

In addition to any other limitations under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.

TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (Vernon 2008).

This section was added as a part of House Bill 4 to limit the recovery of medical expenses. *See* The Medical Malpractice & Tort Reform Act of 2003, 78th Leg., R.S., ch. 204, § 13.08, 2003 Tex. Gen. Laws 847, 889; *see also* Michael S. Hull et al., *House Bill 4 and Proposition 12: An Analysis with Legislative History, Part Three*, 36 TEX. TECH. L. REV. 169, 318 (2005).

The provision was originally limited to medical or health care claims and expressly abrogated the collateral source rule with respect to Medicare, Medicaid, workers' compensation, state or federal

disability benefits, and private health insurance benefits. Judge Randy Wilson, *Paid or Incurred An Enigma Shrouded in a Puzzle*, 71 TEX. B.J. 812, 814 (2008). The version that passed the House did not contain the collateral source provision and the Senate version expanded the coverage of the provision to all personal injury claims. *Id.*

This provision engendered much debate between the plaintiffs' bar, the defense bar, and judges with respect to how the statute should be applied, especially with respect to the issue of determining at what point in time the provision should be applied. It was not until the Texas Supreme Court decided *Haygood v. De Escabedo, supra*, that these issues were put to bed, at least for the foreseeable future.

Haygood sued for injuries he sustained as a result of a car accident. Twelve health care providers billed Haygood a total of \$110,069.12, but because he was covered by Medicare Part B, they adjusted their bills with credits of \$82,329.69, leaving a total of \$27,739.43.¹ Invoking Section 41.0105, the defendant moved to exclude evidence of medical expenses other than those paid or owed. Haygood, asserting application of the collateral source rule, moved to exclude evidence of any amounts other than the total billed, and of any adjustments. The trial court ruled in favor of Haygood and allowed him to put on evidence of his gross medical expenses. The Tyler Court of Appeals reversed.

The Texas Supreme Court began its analysis with a discussion of the collateral source rule. The court disagreed with Haygood that an adjustment in billed medical charges is a collateral benefit covered by the rule, noting that any adjustment in the amount of the charges is a benefit to the insurer, one it obtains from the provider for itself, not for the insured. 356 S.W.3d at 395. The court ultimately concluded that the collateral source rule does not allow recovery of medical expenses a health care

¹ In noting the existence of these adjustments, the Texas Supreme Court noted that federal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable. 356 S.W.3d at 392 (citation omitted). Later in this paper, we will discuss whether that statement is completely accurate and, if so, what impact it has on the issues presented herein.

provider is not entitled to charge because to allow such recovery would constitute a windfall for the claimant. *Id.* at 396.

The court then turned its attention to Section 41.0105, noting that the effect of the statute is likewise to prevent a windfall to the claimant, and concluding that the provision limits a claimant's recovery of medical expenses to those which have been paid or must be paid by or for the claimant. *Id.* at 397-98.

Turning to the question of what evidence should be admissible at trial, the court found that only evidence of recoverable medical expense is admissible. *Id.* at 399.² The court did note that the collateral source rule continues to apply to such expenses and the jury should not be told that these charges will be covered in whole or in part by insurance, nor should the jury be told that a health care provider adjusted its charges because of insurance. *Id.* at 400.

One of the more interesting comments made by a court in construing Section 41.0105 was a statement made by the San Antonio Court of Appeals in *Mills v. Fletcher*, 229 S.W.3d 765 (Tex. App.—San Antonio 2007, no pet.), wherein the court noted that it was not likely that in passing this provision the Legislature ever considered the possibility that people would risk not having their bills covered by insurance just to make sure that a defendant would not benefit from such coverage. *Id.* at 770.

III. THE RULES REGARDING THE DUTY TO MITIGATE

One of the issues to be discussed later in the paper is whether a defendant could make an argument that a plaintiff's (or his or her health care provider's) failure to submit bills to Medicare or to a private health insurer constitutes a violation of the duty to mitigate. In order to better understand whether this is a viable argument, this paper takes a brief look at the duty to mitigate under Texas law.

² This part of the holding has found its way into the Texas Rules of Evidence. See TEX. R. EVID. 902(10)(c) (medical expenses affidavit). The comment to the rule provides that the affidavit is intended to comport with Section 41.0105. The comment also notes that the records attached to the affidavit must meet the admissibility standard adopted in *Haygood*.

Texas law recognizes the doctrine of avoidable consequences or the duty to mitigate damages.

Pulaski Bank & Trust Co. v. Texas Am. Bank/Fort Worth, N.A., 759 S.W.2d 723, 735 (Tex. App.—Dallas 1988, writ denied). A plaintiff cannot recover damages that do not result proximately from tortfeasor's breach and thus damages that might be avoided or mitigated are not recoverable. *Id.* Public policy requires that persons should be discouraged from wasting their resources, both physical and economic. *Id.* (citing RESTATEMENT (SECOND) OF TORTS § 918 cmt. a (1965)).

Basically, the doctrine of mitigation requires an injured person to act reasonably to avoid or prevent losses. *Cotton v. Weatherford Bancshares, Inc.*, 187 S.W.3d 687, 708 (Tex. App.—Fort Worth 2006, pet. denied). The doctrine of mitigation is a branch of contributory negligence in the sense that damages resulting from the failure to mitigate are ultimately not proximately caused by the wrongdoer, but by the injured person's own conduct. *Moulton v. Alamo Ambulance Serv., Inc.*, 414 S.W.2d 444, 449 (Tex. 1967).

The doctrine of mitigation applies to both tort and contract cases. *Formosa Plastics Corp., USA v. Kajima Int'l, Inc.*, 216 S.W.3d 436, 458-59 (Tex. App.—Corpus Christi 2006, pet. denied). The duty to mitigate is only applicable where the party seeking damages has knowledge of the fact which makes avoidance necessary and if damages can be avoided with only slight expense and reasonable effort. *Pulaski Bank & Trust Co.*, 759 S.W.2d at 735; see *Alamo Community College Dist. v. Miller*, 274 S.W.3d 779, 788 (Tex. App.—San Antonio 2008, no pet.) (duty arises only if it can be accomplished with trifling expense or with reasonable exertions).

The doctrine of mitigation is an affirmative defense. *Taylor Foundry Co. v. Wichita Falls Grain Co.*, 51 S.W.3d 766, 774 (Tex. App.—Fort Worth 2001, no pet.).

The burden is on the defendant to show that the plaintiff did not use ordinary care in reducing or avoiding damages. *Miller*, 274 S.W.3d at 788. The defendant also has the burden of establishing the amount by which damages were increased by the plaintiff's failure to mitigate. *City of McAllen v. Casso*,

2013 WL 1281992, at *11 (Tex. App.—Corpus Christi 2013, no pet.) (mem. op.);³ *Formosa Plastics Corp., USA*, 216 S.W.3d at 459 (defendant not required, however, to prove an exact amount of damages but is required to present evidence from which jury can make a reasoned calculation).

In *Formosa Plastics Corp., USA v. Kajima Int'l, Inc.*, *supra*, the court noted that in order for a defendant to be entitled to a mitigation instruction, the evidence (1) must show that the plaintiff's decision not to mitigate caused further damage, and (2) must guide the jury in determining which damages were attributable to the plaintiff's decision not to mitigate. 216 S.W.3d at 459.⁴

There is little to no case authority in Texas on the issue of mitigation and medical expenses, save and except for *Casso* and that case does not directly deal with the matter at issue in this paper.

The only other appellate cases that even come close to addressing the matter at issue are Jones Act cases dealing with the issue of maintenance and cure. In *Kratzer v. Capital Marine Supply, Inc.*, 645 F.2d 477 (5th Cir. 1981 Unit A), the court noted that a seaman has a duty to mitigate costs of cure by accepting an employer's tender of free medical treatment through a public health service unless the seaman could show that the services provided were inadequate. *Id.* at 482. In *Moran Towing & Transp., Co. v. Lombas*, 58 F.3d 24 (2d Cir. 1995), the court held that the availability of medical care under a Medicare program satisfied the vessel owner's obligation to furnish cure. *Id.* at 26.

³ In *Casso*, a municipal judge offered to settle with the City in exchange for continued health care coverage after her health condition was allegedly aggravated by unsanitary working conditions. After the City cancelled her coverage, the judge sued. The City complained that Casso had failed to mitigate her damages because she failed to obtain alternate health care coverage. The court concluded that the evidence did not support an instruction on failure to mitigate because although there was testimony she might have qualified for coverage available through the internet despite her pre-existing condition (case obviously decided before implementation of Obamacare), the City failed to produce evidence that she failed to show diligence in pursuing insurance. *Id.* (Casso had sought coverage but had been denied twice by other carriers).

⁴ Depending on how strictly a court were to construe the requirement that evidence show the failure to mitigate caused further damages, application of this doctrine to a failure to pursue health care coverage could be problematic. This is not the language typically used by courts, however. Most just use language suggesting that the doctrine prevents the plaintiff from recovering for damages that could have been avoided by reasonable efforts on the part of the plaintiff. *See, e.g., Great Am. Ins. Co. v. North Austin Municipal Utility Dist. No. 1*, 908 S.W.2d 415, 426 (Tex. 1995).

There is an opinion out of a trial court in Indiana that is very interesting. In *Buss v. Trancik*, 2012 WL 4739226 (Ind. Super. Ct. 2012), the court was asked to determine, by way of declaratory relief, the proper amount a doctor was equitably entitled to receive from a liability settlement received by his patient. The doctor performed emergency orthopedic surgery and provided follow-up services for the plaintiff as a result of a car accident. His bills totaled \$40,657. The plaintiff's total medical expenses exceeded \$138,000. Plaintiff settled her claim against the other driver for \$100,000. Medicare, Anthem Blue Cross and Blue Shield, and Tricare all paid a portion of the plaintiff's medical expenses. The doctor did not have a contractual agreement with any of these health care providers, but the evidence established that he routinely treated patients insured by these entities and billed them for the care. The doctor refused to submit his charges to any of her health insurance carriers. The doctor claimed that the agreement signed by the plaintiff personally promising payment of all charges and assigning her rights to him supported his interest in the third-party liability settlement proceeds.

Looking to Indiana law, the court noted that a treating physician has a duty to fill out insurance forms, a meritorious requirement in view of increased dependence upon medical insurance as a means of combating rapidly rising health care costs. The court concluded that the doctor had a duty to complete the insurance forms seeking reimbursement from the private health carriers.⁵ Noting that insurers generally pay about forty cents per dollar of billed charges, the court determined that this was a reasonable amount for the doctor's services. Therefore, the doctor was only able to recover a little over \$16,000.

IV. THE COLLATERAL SOURCE RULE

The one-satisfaction rule limits a plaintiff to but one satisfaction for the injuries sustained by him. *Imperial Lofts, Ltd. v. Imperial Woodworks, Inc.*, 245 S.W.3d 1, 5 (Tex. App.—Waco 2007, pet. denied).

⁵ The doctor argued that he was prohibited from collecting payment from Medicare when payment has been made or can reasonably be expected to be made promptly under a liability insurance policy. This paper will address this issue in depth at a later point. Although the court agreed with the doctor, promptly means 120 days from treatment. Settlement in this case was over a year after treatment. The doctor could rightfully have sought conditional payment. Therefore, the court's analysis of this issue was a little simplistic.

Under this rule, it would appear that allowing recovery of a compensatory damage element paid by a collateral source has the appearance of a forbidden double recovery. But, if payment falls within the collateral source rule, the foregoing rule is not applicable. *Haygood*, 356 S.W.3d at 394.

The collateral source rule provides:

[T]he fact that an injured person receives from a collateral source payments which may have some tendency to mitigate the consequences of the injury which he otherwise would have suffered may not be taken into consideration in assessing the damages or other recovery to which the claimant may be entitled.

Traders & General Ins. Co. v. Reed, 376 S.W.2d 591, 593 (Tex. Civ. App.—Corpus Christi 1964, writ ref'd n.r.e.).

The collateral source rule is both a rule of evidence and damages. *Johnson v. Dallas County*, 195 S.W.3d 853, 855 (Tex. App.—Dallas 2006, no pet.). The rule precludes a tortfeasor from obtaining the benefit of, or even mentioning, payments to the injured party from sources other than the tortfeasor. *LMC Complete Automotive, Inc. v. Burke*, 229 S.W.3d 469, 480 (Tex. App.—Houston [1st Dist.] 2007, pet. denied).⁶

Application of the collateral source rule has historically benefitted those with the foresight to purchase insurance in advance of an injury or at least in advance of treatment. *See Haygood*, 356 S.W.3d at 394 (rule precludes any reduction in defendant's liability because of benefits received by the plaintiff from another source like an insurance policy). The rule furthers public policy by encouraging insurance coverage and allowing benefits to reach their intended beneficiaries in full.

The theory behind the rule is that a wrongdoer should not have the benefit of insurance independently procured by the injured party. *Haygood*, 356 S.W.3d at 305. Underlying the collateral

⁶ Of course, like every other rule in the law, this rule has some exceptions. Evidence of a collateral source may be admissible for impeachment purposes when a witness opens the door by giving testimony inconsistent with the receipt of benefits. *Id.*; *Mundy v. Shippers, Inc.*, 783 S.W.2d 743, 745 (Tex. App.—Houston [14th Dist.] 1990, writ denied); *J.R. Beadel & Co. v. De La Garza*, 690 S.W.2d 71, 74 (Tex. App.—Dallas 1985, writ ref'd n.r.e.).

source rule is the equitable notion that if there must be a windfall, the injured party is more justly entitled to it than the wrongdoer. *Sweep v. Lear Jet Corp.*, 412 F.2d 457, 459 (5th Cir. 1969).

As previously noted, not every benefit falls within the scope of the collateral source rule. *See Haygood*, 356 S.W.3d at 395 (adjustment in billed medical charges is not a collateral benefit covered by the rule); *see also Wise v. Peterson (In re Peterson)*, 452 B.R. 203, 223 (Bankr. S.D. Tex. 2011) (since insurance carrier is only obligated to pay a reduced amount for medical expenses, it would undermine the made-whole doctrine to allow a plaintiff to recover expenses above and beyond those which he or his carrier were actually obligated to pay).

The collateral source rule, and especially with respect to the issue of recoverable medical expenses, has lost much of its import. *See Benjamin A. Geslison & Kevin T. Jacobs, The Collateral Source Rule and Medical Expenses: Anticipated Effects of the Affordable Care Act and Recent State Case Law on Damages in Personal Injury Lawsuits*, 80 DEF. COUNS. J. 239, 245-47 (July 2013) (noting that between statutory changes and case law, approximately 35% of the US population now lives in states where the list price for medical services no longer represents the recoverable amount of medical damages for a claimant).

V. Chapter 146

There is a provision in the Texas Civil Practice and Remedies Code that has apparently been overlooked by many, including those on the provider side of the equation. Chapter 146 deals with a potential bar to certain claims by health care service providers. This statutory provision can be very costly for medical care providers and plaintiffs alike.

Section 146.001 contains the definitions applicable to this chapter:

In this chapter:

- (1) “Health benefit plan” means a plan or arrangement under which medical or surgical expenses are paid for or reimbursed or health care services are arranged for or provided. The term includes:

- (A) an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract;
 - (B) an evidence of coverage or group subscriber contract issued by a health maintenance organization or an approved nonprofit health corporation;
 - (C) a benefit plan provided by a multiple employer welfare arrangement or another analogous benefit arrangement;
 - (D) a workers' compensation insurance policy; or
 - (E) a motor vehicle insurance policy, to the extent the policy provides personal injury protection or medical payments coverage.
- (2) "Health care service provider" means a person who, under a license or other grant of authority issued by this state, provides health care services the costs of which may be paid for or reimbursed under a health benefit plan.

TEX. CIV. PRAC. & REM. CODE ANN. § 146.001 (Vernon 2011).

Section 146.002 governs timely billing requirements. It provides:

- (a) Except as provided by Subsection (b) or (c), a health care service provider shall bill a patient or other responsible person for services provided to the patient not later than the first day of the 11th month after the date the services are provided.
- (b) If the health care service provider is required or authorized to directly bill the insurer of a health benefit plan for services provided to a patient, the health care service provider shall bill the issuer of the plan not later than:
 - (1) The date required under any contract between the health care service provider and the issuer of the health benefit plan; or
 - (2) if there is no contract between the health care service provider and the issuer of the the health benefit plan, the first day of the 11th month after the date the services are provided.
- (c) If the health care service provider is required or authorized to directly bill a third party payor operating under federal or state law, including Medicare and the state Medicaid program, the

health care service provider shall bill the third party payor not later than:

- (1) the date required under any contract between the health care service provider and the third party payor or the date required by federal regulation or state rule, as applicable; or
 - (2) if there is no contract between the health care service provider and the third party payor and there is no applicable federal regulation or state rule, the first day of the 11th month after the date the services are provided.
- (d) For purposes of this section, the date of billing is the date on which the health care service provider's bill is:
- (1) mailed to the patient or responsible person, postage prepaid, at the address of the patient or responsible person as shown on the health care service provider's records; or
 - (2) mailed or otherwise submitted to the issuer of the health benefit plan or third party payor as required by the health benefit plan or third party payor.

TEX. CIV. PRAC. & REM. CODE ANN. § 146.002 (Vernon 2011).

Section 146.003 determines when claims are barred by statute. It provides:

- (a) A health care service provider who violates Section 146.002 may not recover from the patient any amount that the patient would have been entitled to receive as payment or reimbursement under a health benefit plan or that the patient would not otherwise have been obligated to pay had the provider complied with Section 146.002.
- (b) If recovery from a patient is barred under this section, the health care service provider may not recover from any other individual who, because of a family or other personal relationship with the patient, would otherwise be responsible for the debt.

TEX. CIV. PRAC. & REM. CODE ANN. § 146.003 (Vernon 2011).

Finally, Section 146.004 protects the health care service provider from disciplinary actions arising out its failure to comply with chapter 146. It provides:

A health care service provider who violates this chapter is not subject to disciplinary action for the violation under any other law, including the law under which the health care service provider is licensed or otherwise holds a grant of authority.

TEX. CIV. PRAC. & REM. CODE ANN. § 146.004 (Vernon 2011).

Chapter 146 has not been the subject of much discussion by the courts. In fact, the only reported case dealing with Chapter 146 is *Speegle v. Harris Methodist Health Sys.*, *supra*, which dealt with whether federal law preempted the application of Chapter 146 in a case involving Medicare. That case will be discussed in greater detail later in this paper.

This firm recently handled a case that involved application of Chapter 146. In that case, a prominent hospital filed a lien in an amount of approximately \$280,000 in a case involving an injured worker whose employer maintained workers' compensation coverage. The hospital did not submit the bills for payment under the workers' compensation system. Our firm represented a potentially responsible third party. In order to understand how the statute worked to our client's benefit, it is important to get a little background on workers' compensation cases and statutory liens.

Section 413.001 of the Labor Code provides for the adoption of fee guidelines and health care reimbursement policies for services provided to employees covered under the Texas Workers' Compensation Act. TEX. LABOR CODE ANN. § 413.001 (Vernon Supp. 2012). Section 134.1 of the Texas Administrative Code likewise outlines issues related to the maximum allowable reimbursements for health care provided subject to the workers' compensation system. 28 TEX. ADMIN. CODE § 134.1 (West 2014). Without going into the details of the system, it is fair to say that the fee guidelines do not permit recovery of list prices.

Section 413.042 of the Labor Code provides:

- (a) A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless:

- (1) the injury is finally adjudicated not compensable under this subtitle; or
 - (2) the employee violates Section 408.022 relating to the selection of a doctor and the doctor did not know of the violation at the time the services were rendered.
- (b) A health care provider commits an administrative violation if the provider violates Subsection (a).

TEX. LABOR CODE ANN. § 413.042 (Vernon 2006).

Finally, it should be remembered that a hospital lien does not attach to a claim under the workers' compensation law. TEX. PROP. CODE ANN. § 55.003(b)(1) (Vernon 2007).

In *McCollum v. Baylor Univ. Med. Ctr.*, 697 S.W.2d 22 (Tex. App.—Dallas 1985, no writ), the court noted that in return for its right to pursue the workers' compensation carrier directly for payment of bills, the hospital relinquishes its remedy of pursuing the injured worker, finding that this trade-off was a fair one which the hospital must make to claim the benefits of the Workers' Compensation Act. *Id.* at 26.⁷

In *Daughters of Charity Health Servs. v. Linnstaedter*, 226 S.W.3d 409 (Tex. 2007), the court was faced with the question of whether a hospital paid by a workers' compensation carrier could recover the discount from its full charges by filing a lien against the employee's tort recovery. In that case, two employees were injured in an auto accident while in the course of their employment. They were treated at a hospital owned and operated by the Daughters of Charity Health Services. The reasonable and necessary hospital charges were over \$22,000, of which their workers' compensation carrier paid \$9,737.54.

The hospital did not dispute that this was all that was due under the reimbursement guidelines mandated by the Texas Labor Code. The hospital filed a lien with the county clerk for the difference

⁷ The court did note that the rights and liabilities between the third-party tortfeasor and the hospital were not governed by the Act, but instead were governed by the lien statute. *Id.*

between the two amounts. When the lawsuit against the other driver was ultimately settled, the carrier for the third party paid \$12,966.71 to the hospital to discharge the lien. The employees then filed suit against the hospital for recovery of that sum claiming that the lien was invalid under the Labor Code. The hospital argued that the lien was valid under the Property Code. *Id.* at 410.

The court noted that the Texas Property Code grants hospitals a lien on any cause of action a patient may have against a tortfeasor. The court also noted that to ensure full coverage for employees protected by workers' compensation, the Texas Labor Code provides that hospitals may not pursue a private claim against the workers' compensation claimant for all or part of the costs of treatment. *Id.* at 411. The court concluded that the two provisions could be given effect by limiting hospital liens involving compensation patients to amounts due under the workers' compensation system. *Id.* The court noted that granting hospitals a lien in excess of the established guidelines for fair and reasonable rates would frustrate the Legislature's effort to achieve effective medical cost control. *Id.* at 412. The court further noted that if a workers' recovery could be reduced by a hospital lien, the hospital would be reimbursed more than the compensation guidelines and the carrier would have to pay more in future medical benefits. *Id.*

One of the more interesting parts of the entire opinion was the court's discussion of the basis for liens for medical services. The court explained that a lien is part and parcel of the underlying claim, the former existing only because of the latter. *Id.* at 411. As a chose in action is the intangible personal property of the injured party, a lien against such property is necessarily a claim against its owner. *Id.* A hospital has neither tort nor contract rights against a tortfeasor who has injured a patient. The only support for the hospital lien is its claim for reimbursement from the patient. *Id.*

Thus, a lien against a tort recovery is just as much a claim against the patient as if it were filed against the patient's house or bank account. *Id.*

Despite the requirements of Chapter 146, the hospital did not submit its bills for payment to the workers' compensation insurance carrier in a timely manner, instead deciding to roll the dice on its lien against the tort suit. Our firm prepared a declaratory judgment arguing that the lien was not valid because under Section 146.003(a), the hospital's failure to timely submit bills for payment precluded any recovery from the patient of any amount that the patient would have been entitled to receive as payment or reimbursement or that the patient would not otherwise have been obligated to pay as a result of the same plan.

Since the hospital's lien is only as good as its claim against the patient, the lien was invalid. Was it our brilliant argument? Who knows, but the hospital quietly folded its tent and went away, withdrawing its lien.⁸

Given the potential of Chapter 146, defendants should be pursuing discovery of the existence of contracts between health care providers and insurance companies. One court has countenanced such discovery. In the case of *In re Jarvis*, 2013 WL 4759648 (Tex. App.—Houston [14th Dist.] 2013, no pet.), the defendant sought discovery of any contracts between Blue Cross and Blue Shield and the doctors and hospitals that provided medical services to the plaintiff. The plaintiff argued that this discovery ran afoul of the collateral source rule. The court concluded that the defendant was entitled to the discovery pursuant to Section 41.0105 to aid in determining whether the providers were required to accept payments of less than the amounts billed. *Id.* at *7. A good argument can be made that this same discovery would go to the issue of whether the contracts required the health care providers directly bill the carrier, thus potentially invoking Chapter 146.

VI. STATUTORY LIMITS ON RECOVERABLE MEDICAL EXPENSES

⁸ Although we never actually filed the petition, we had also intended to sue the plaintiff for a declaration that since the hospital's lien was not valid, the patient had not actually incurred any medical expenses under 41.0105, so he could not seek medical from the defendant. Probably a tougher argument to win, especially with a trial judge, but it should be kept in mind for future cases.

This paper has previously addressed the limits on recoverable medical expenses under the Texas Workers' Compensation Act. This portion of the paper will focus on Medicare. We will begin with a review of what appear to be the relevant statutory provisions. We will then turn our attention to two cases that have addressed the issue of Medicare's secondary payor status and recoverable medical expenses.

For purposes of this paper, there are two relevant statutory provisions: (1) the Provider Agreement Statute; and (2) the Secondary Payor Statute.

A. THE PROVIDER AGREEMENT STATUTE.

Section 1995cc, entitled "Agreements with Providers of Services," provides in pertinent part:

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

...

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395l(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the

reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under Part B of this subchapter....

42 U.S.C § 1395cc(a).

Regulations enacted pursuant to this statutory provision help illustrate the limits on what a health care provider may bill for providing services to a Medicare eligible patient. Section 504.501 generally provides that Medicare pays not more for Part B medical and other health services than the “reasonable charge” for such service. 42 C.F.R. § 405.501(a). Section 405.502 sets out the criteria for the determination of what constitutes a reasonable charge. 42 C.F. R. § 405.502(a). Without getting bogged down in the minutiae of what is a reasonable charge, commentators have noted that Medicare’s reasonable charge may well be only 25-35 percent of the health care provider’s full rates. Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49-APR HOUS. LAW. 24, 25 (2012).

Finally, Section 424.44 sets the time limits within which a health care provider must submit a claim for payment for services. Subject to certain extensions to be granted on the whim of CMS, for services furnished on or after January 1, 2010,

the claim must be filed no later than the close of the period ending one calendar year after the date of service. 42 C.F.R. c21 424.44(a)(1).⁹

Chapter 1 Paragraph 70.4 of the Medicare Claims Processing Manual¹⁰ notes that Medicare will deny a claim for untimely filing if the receipt date applied to the claim exceeds 12 months from the date the services were furnished and such determination is not subject to appeal.

⁹ Prior to January 1, 2011, providers had almost two years to file some claims, depending upon when in the year the service was provided. This longer time within which to file claims may have been a motivating factor for some of the decision to be discussed later in this section.

B. THE SECONDARY PAYOR STATUTE.

The controlling provisions of the Secondary Payor Statute are set out in 42 U.S.C. §1395y, entitled “Exclusions from Coverage and Medicare as Secondary Payer.” Subsection (b)(2) defines Medicare as a secondary payer and provides:

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

...

- (ii) payment has been made or can reasonably be expected to be made under a workmens’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under not fault insurance.

In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies....

(B) Conditional payment

- (i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or serve promptly...Any such payment by the Secretary shall be conditional on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

42 U.S.C. § 1395y(b)(2).

¹⁰ This manual can be found at www.cms.hhs.gov/manuals. Click on the Internet Only Manual tab and then click on PUB 100-04.

Federal regulations promulgated pursuant to this statutory provision likewise expand on the language. Section 411.32 provides that Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary. 42 C.F.R. § 411.32(a)(1). Section 411.50 sets out certain general provisions regarding Medicare's secondary payer status. 42 C.F.R. § 411.50. Subsection (b) defines "promptly" to mean, when used in connection with payment by a liability insurer, payment within 120 days after the earlier of (1) the date a claim is filed with an insurer or a lien is filed against a potential settlement, and (2) the date the service was furnished. *Id.* at § 411.50(b).

The Medicare Secondary Payer (MSP) Manual¹¹ provides that health care providers have billing options where liability insurance is in play. Paragraph 40.2 provides that providers and physicians must bill liability insurance prior to the expiration of the promptly period (120 days) rather than bill Medicare. Following the expiration of this 120 day period, the provider or physician may either (1) bill Medicare for payment and withdraw all claims/liens against the liability insurance/settlement, or (2) maintain all claims/liens against the liability insurance/settlement.¹² The MSP also provides that if the provider bills Medicare, it must accept the Medicare approved amount as payment in full, but if the provider pursues the liability insurance, it may charge beneficiaries actual charges up to the amount of the proceeds of the liability insurance.

This paper now turns to two of the most recent cases to have addressed the issue of Medicare's secondary payer status and the question of reasonable medical charges.¹³ In *Speegle v. Harris Methodist*

¹¹ This manual can be found at www.cms.hhs.gov/manuals. Click on the Internet Only Manual tab and then click on PUB 100-05.

¹² Interestingly, 42 C.F.R. § 411.54(d) provides special rules for Oregon – the provider must withdraw its claim or lien if not paid within the 120 day period. This exception is also noted in the MSP manual.

¹³ Earlier cases had already held that under prior versions of the statutory provisions at issue, a provider was not prevented from pursuing a lien against liability insurance to collect more than the provider could have collected if it billed Medicare within a timely manner. *See, e.g., American Hosp. Ass'n v. Sullivan*, 1990 WL 274639, at *9 (D.

Health Sys., supra, the hospital did not bill Medicare even though the patient was Medicare eligible. Instead, it filed a lien against a potential tort recovery seeking its full charges. The patient filed for declaratory relief seeking a declaration that the hospital lien was invalid because the hospital did not comply with Chapter 146 by timely billing Medicare. The court began its discussion with the recognition that prior to 1980, Medicare was the primary payer for services received by its beneficiaries. *Id.* at 36. However, in 1980, Congress enacted the secondary payer provisions for situations in which the beneficiary is potentially covered by other insurance. These changes were designed to achieve major fiscal savings. *Id.*

Citing 42 U.S.C. § 1395y(b)(2)(A), the court found that the statute prohibits Medicare from paying for services if a liability carrier has already paid or is reasonably expected to pay promptly (120 days). *Id.* at 37. The court then turned to a 1995 memorandum issued by the Health Care Financing Administration (predecessor to CMS) providing that a supplier may, but is not required to bill Medicare for conditional payment if the liability insurance claim is not finally resolved.¹⁴ *Id.*

The court noted that the same construction of the statute was published in the Medicare Secondary Payer Manual (cited above). *Id.* The court concluded that a provider, under the language of the MSP and the 1995 memorandum, has a right to either bill Medicare or maintain its lien after the 120 day period. *Id.* at 37-8.

D.C. 1990); *Oregon Ass'n of Hosps. v. Bowen*, 708 F. Supp. 1135, 1141 (D. Or. 1989); *Joiner v. Medical Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998). Interestingly, in the first two cases cited in this footnote, it was the Department of Health and Human Services that argued for the limitation on recoverable medical expenses.

¹⁴ The 1995 memorandum was basically repeated in a 1996 memorandum issued by the Director of the Office of Chronic Care and Insurance Policy of the Department of Health & Human Services. A copy of the 1996 memorandum is attached hereto as Exhibit A. The 1996 memorandum once again repeated the options available to a provider after the 120 day period expires: bill Medicare and withdraw claims/liens or continue to pursue liability insurance/lien, but not bill Medicare. By submitting the bills to Medicare, the provider agrees to payment of the Medicare allowed amount. The memorandum thus suggests that the provider is entitled to collect actual charges if it continues to pursue the proceeds of liability insurance.

The court then turned to Chapter 146 and determined that it was preempted by the secondary payer requirements of the federal Medicare scheme to the extent that it requires a hospital to bill Medicare as a primary source of payment when other funds are available. *Id.* at 40.

Approximately four years later, the Wisconsin Court of Appeals issued its opinion in *Laska v. General Cas. Co.*, 830 N.W.2d 252 (Wisc. Ct. App. 2013), which once again addressed the question of whether a hospital could enforce a lien after the Medicare billing period expires. The court began its analysis with the recognition that there is an inherent conflict between the Provider Agreement Statute and the Secondary Payor Statute. *Id.* at 256. The court then undertook a discussion of both provisions and prior case law. In light of the statutory scheme and the earlier cases, the court determined that when a liability insurer has paid or can reasonably be expected to pay, a Medicare beneficiary is not “entitled” to have services paid by Medicare such that the provisions of the Provider Agreement Statute limiting charges is not applicable. *Id.* at 260.

The court then undertook a discussion of the 1995 and 1996 memorandums addressed in *Speegle*. The court was also presented with a 2000 memorandum that was not discussed in *Speegle*.¹⁵ The 2000 memorandum, issued by the Deputy Director of the Division of Integrated Delivery Systems of the Department of Health & Human Services provides that the earlier memoranda did not fully explain the potential consequences of a provider’s decision to continue pursuing the liability insurer after the 120 day period expires. The memorandum also noted that the earlier memoranda did not explain whether providers can continue to use liens to collect after the Medicare timely filing period expires.

The 2000 memorandum took the position that the providers of services to Medicare beneficiaries are required to drop their liens and terminate all billing efforts to collect from a liability insurer or beneficiary once the timely filing period expires, unless the claim was paid or settled prior to the expiration of that period. The 2000 memorandum cited section 1866(a)(1)(A) of the Social Security Act

¹⁵ A copy of the 2000 memorandum is attached hereto as Exhibit B.

which prohibits providers from charging Medicare beneficiaries or any other person for items or services for which Medicare would have paid if the provider had filed a claim with Medicare.

The court concluded that the 2000 memorandum was not a reasonable interpretation of the Secondary Payor Statute. *Id.* at 261. The court noted that following the 2000 memorandum would have a tendency to encourage providers to bill Medicare rather than gamble on whether the underlying claim would settle before the Medicare billing period expires. *Id.* at 263. The court dismissed any reliance on the right of Medicare to subrogate for conditional payments finding that Medicare should not have to face the risk of no recovery (as opposed to the health care providers – and who likes them anyway?). *Id.* The court did acknowledge that the 2000 memorandum was consistent with the purpose expressed in the legislative history of the statute of protecting the beneficiary’s pocketbook by ensuring that his tort recovery was not diminished, but determined that this was simply not enough to override its view of the importance of the secondary payer provision. *Id.*

The court ultimately concluded that the hospital could enforce its lien for the actual charges.

Would *Speegle* have been decided differently had the court been made aware of the 2000 memorandum? There is no way of knowing. The court could have simply chosen to ignore the later memorandum in favor of the earlier memoranda that supported its position like the court did in *Laska*. There is at least another argument that can be made given the existence of the later memorandum from HHS.

VII. ARGUMENTS THAT MAY EXIST FOR THE DEFENSE BAR

In the foregoing section, this paper addressed service provider’s efforts to get around Medicare reductions by choosing not to pursue Medicare, even after the 120 day period. In at least two cases, they have been successful. The fact that the period in which a Medicare claim must be filed has been shortened, combined with the statutory effect of the failure to file a timely claim, along with the 2000 memorandum, may provide fresh ammunition for the defense bar.

In *Haygood*, the Texas Supreme Court stated that federal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable. 356 S.W.3d at 392. While this is an accurate statement of the law as set forth in the Provider Agreement Statute, HHS/CMS do not agree. Of course, except in Fort Worth, courts are only bound by the statute, not by memorandums and manuals.

As noted, the 2000 memorandum notes that once the billing period for Medicare ends (now one year), the provider can no longer pursue a claim against the beneficiary. Since any lien exists only because of a claim against the beneficiary, as noted in *Daughters of Charity Health Servs. v. Linnstaedter*, *supra*, any lien should no longer be valid after one year. This is pretty much a Chapter 146 argument and even the court in *Speegle* noted that Chapter 146 was only preempted to the extent it required the provider to bill Medicare as a primary payer.

Doctors and other health care providers also seek to avoid reductions imposed by private health carriers by refusing to file claims with these carriers. As discussed above, they do so at their own peril under the provisions of Chapter 146. At least in Indiana, doctors do so only by acting in contravention of their obligations to their patients.

Does a mitigation argument exist with respect to reasonable medical expenses as determined by the government and private health care providers?

There is no question that it is common knowledge that insurance pays less than full boat for medical expenses. If it were not, providers would not be playing their games. Any person who has private health insurance knows this fact. Second, there is no significant expense to the plaintiff involved with filing a claim for health care benefits under a private policy or under Medicare. The doctors fill out most forms.

I suppose the plaintiff could argue that filing a claim means that he or she will be responsible for a deductible, but given the cost of medical care, that is a trifling expense. The potential problems that

exist with a mitigation argument are: (1) evidentiary - the defendant will have to obtain experts on the issue of the amount of reduction in medical expenses had the claim been submitted to Medicare or a private health insurer to establish how much damages could have been mitigated; and (2) the jury would necessarily have to be told about the existence of insurance which runs afoul of the collateral source rule. Finally, this is not an argument that is likely to gain much traction with trial judges. So, you are going to have to find a client that is willing to incur the cost of appealing this issue (maybe repeatedly until we can get the Supreme Court interested).

A possible route for some of these arguments may be a declaratory relief action against the health care provider. This would help avoid issues related to a jury hearing about the existence of insurance.

These may well be issues to be presented to the Texas Legislature.

VIII. CONCLUSION

While there are a number of good arguments to be made with respect to what constitutes reasonable medical expenses, unfortunately there is no simple answer to any of the questions presented. While the collateral source rule still has teeth in Texas, the courts do not seem enamored with the concept of windfalls, especially in light of the made-whole doctrine.

We are sure that many of you read this paper hoping for an easy answer to some perplexing questions. Unfortunately, the best we can do is present the questions and the law. You will have to find the right case and the right court.

About the Author:

Craig L. Reese – Partner of the firm, Craig leads the appellate and coverage practice group. He has over 23 years practice experience including appeals at the federal and state level, insurance coverage/defense, and commercial litigation. His appellate experience includes cases before every level of the state courts of appeals and appeals to the Fifth Circuit Court of Appeals.