

# **To Bill or Not to Bill, That is the Question: Hospital Liens vs. Billing Medicaid or Medicare**

by Robert W. Fechtman

Hospitals are often in a position where they must provide emergency services to injured patients, without knowing whether the patients have the ability to pay for these services. Hospital lien statutes relieve some of this burden on hospitals by giving them the ability to obtain liens upon any funds the patients may ultimately receive as compensation for their injuries. However, questions often arise concerning the enforceability of these hospital liens in cases where the patient is eligible for Medicaid or Medicare.

## **Hospital Liens vs. Billing Medicaid:**

In the 7<sup>th</sup> Circuit, the case of *Evanston Hospital v. Hauck*<sup>1</sup> held that a hospital may not enforce its statutory lien rights, if the hospital accepts any payment from Medicaid for medical services provided to the patient. This essentially means that a hospital must choose between its hospital lien and billing Medicaid. Part of the Circuit Court's rationale is that federal Medicaid regulations require that medical service providers who participate in the Medicaid programs must accept payment from the Medicaid agencies as payment in full.<sup>2</sup> So, medical service providers may not "balance bill" the patient after the medical service providers have been paid by Medicaid.<sup>3</sup> The Seventh Circuit said it best:

"Evanston Hospital was not 'forced' to abandon its right to sue Hauck; no one coerced the hospital into cashing a [Medicaid] check from the taxpayers as partial reimbursement for Hauck's medical bills. Rather, the hospital could have simply forsaken Medicaid and taken its chances that Hauck would somehow come up with the money to pay the bills himself. By opting for reimbursement from Medicaid, Evanston Hospital bought certainty. It purchased a guarantee of partial payment in lieu of possible full payment or possibly no payment at all. . . . Evanston Hospital wants out of its agreement with Medicaid now only because its gamble, in retrospect, was unwise."

This area of the law appears to be well-settled, as evidenced by the holding in the 6<sup>th</sup> Circuit case of *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*<sup>4</sup>, which parallels the holding in *Hauck*.

## **Hospital Liens vs. Billing Medicare:**

As is often the case, the issue is a bit more convoluted when Medicare is involved. On the one hand, the federal Medicare law requires that participating providers not charge

Medicare beneficiaries for any items or services that Medicare should be paying for on their behalf.<sup>5</sup> On the other hand, Congress amended the federal Medicare law in 1965<sup>6</sup> to make Medicare a secondary payer under certain circumstances, and this law was amended again in 1980<sup>7</sup> to specify that Medicare is a secondary payer in relation to automobile or liability insurance plans, when payment from these sources has already been made or can reasonably be expected to be made promptly. This law is codified as amended at 42 U.S.C. 1395y(b)(2)(A)(ii). The obvious intent of this statute is to cut Medicare costs by forcing medical service providers to bill a source of payment other than Medicare whenever another such source of payment is available.

The definitive case for Indiana is the Indiana Court of Appeals case of *Parkview Hospital vs. Roese*,<sup>8</sup> which held that, under federal Medicare law, a hospital may choose whether to bill Medicare, if an insurance settlement has not been finalized, and waive its statutory lien against the injured Medicare recipient, or pursue its statutory lien and waive Medicare reimbursement. So, as with Medicaid, the case law in this area essentially indicates that a hospital must choose between its hospital lien and billing Medicare.

There is some discussion in the *Roese* case that has been rendered moot by a couple of changes in the federal Medicare law. First, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003<sup>9</sup> amended 42 U.S.C. 1395y(b)(2)(A)(ii) to remove the “prompt payment” requirement, although the federal Medicare regulations still define “prompt payment.”<sup>10</sup> Second, the federal Medicare regulations have been amended to remove some language that conflicted with even the old form of the statute by prohibiting the billing or filing of a lien against a liability insurance settlement.<sup>11</sup> These changes are worth mentioning here, because they were anticipated by the Court in *Roese*, due to the fact that counsel for Parkview Hospital had submitted to the Court a letter from the Centers for Medicare and Medicaid Services<sup>12</sup> (“CMS”) addressing Medicare’s secondary payer status with respect to liability insurance. The Court gave authority to this CMS letter, since the Court felt that the letter resolved the apparent conflict in the federal Medicare regulations, and the Court stated that it felt that the letter expressing CMS’ policy with regard to these secondary payer issues was consistent with Congress’s intent according to the statute.

The current CMS policy concerning billing in Medicare secondary payer liability insurance situations may be found on the internet at [www.cms.hhs.gov/manuals/downloads/msp105c02.pdf](http://www.cms.hhs.gov/manuals/downloads/msp105c02.pdf), and it is virtually identical to the contents of the CMS letter described by the Court in *Roese*. This CMS policy states in relevant part:

“Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary’s liability insurance settlement is considered billing the liability insurance.) Promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement;

or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or
- maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

In other words, when it comes to the question of whether or not the hospital should bill Medicare, the hospital has no choice during the first 120 days, as the hospital is simply not allowed to bill Medicare during this period, unless the hospital can demonstrate that liability insurance will not pay during the first 120 days. But, after the first 120 days, the hospital has the choice that now seems so familiar: the hospital may either bill Medicare and withdraw its hospital lien, or the hospital may assert its lien and decide not to bill Medicare.

<sup>1</sup> *Evanston Hospital v. Hauck*, 1 F.3d 540 (7<sup>th</sup> Cir. 1993).

<sup>2</sup> 42 C.F.R. 447.15.

<sup>3</sup> *Mallo v. Pub. Health Trust*, 88 F.Supp.2d 1376 (S.D. Fla. 2000).

<sup>4</sup> *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6<sup>th</sup> Cir. 2005).

<sup>5</sup> 42 U.S.C. 1395cc(a)(1)(A).

<sup>6</sup> Codified as amended at 42 U.S.C. 1395y.

<sup>7</sup> Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2647 (1980).

<sup>8</sup> *Parkview Hospital v. Roese*, 750 N.E.2d 384 (Ind. Ct. App. 2001).

<sup>9</sup> House Bill 1, and Senate Bill 1, of the 108<sup>th</sup> Congress.

<sup>10</sup> 42 C.F.R. 411.50.

<sup>11</sup> 42 C.F.R. 411.54.

<sup>12</sup> At that time, this agency was called the Health Care Financing Administration ("HCFA").