

**Understanding and Resolving Issues
 Regarding ERISA, Medicare,
 Medicaid, Disability Benefits and
 Unpaid Medical Bills**
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Issues with unpaid medical bills

- **R.S.Mo Section 287.140.1** provides:
- **“...in addition to all other compensation paid to the employee, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonable be required after the injury or disability, to cure and relieve the effects of the injury.”**

Historically,

- the law contained both monetary and time limitations on the medical aid to be provided.
- The Act originally provided medical, etc., for first 60 days in an amount not to exceed \$250 and thereafter as ordered by Commission for first year after date of injury. (1926)
- Amendment on 5/14/31 provided medical for first 90 days in an amount not to exceed \$750 and thereafter as ordered by Commission.
- Amendment on 10/9/51 removed all monetary limits.
- Amendment on 8/29/57 provided for resolving disputes as to travel expense.
- Amendment on 10/13/65, time limit for employer's responsibility for medical was increased from 90 to 180 days.
- Amendment on 9/28/77, time limit for medical was deleted.
- The employer may also be required to furnish the "employee with artificial legs, arms, hands, surgical orthopedic joints, or eyes, or braces, as needed, for life" **Section 287.140.8.**

**Responsibility even though
Lack of Cure:**

- While 287.140.1 provides that medical treatment is require "to cure and relieve" the effects of the injury, it is settled that responsibility for medical treatment exists even when no medical treatment is available that would "cure" an injured employee and treatment would only "relieve" the employee. Although the phrase "cure and relieve" is in the conjunctive, it is treated as though the phrase were in the disjunctive, substituting, in effect, the word "or" for "and". Therefore, if treatment will give the employee relief, the employer must provide it, irrespective of the inability of treatment to cure the employee. *Brollier v. Van Alstine*, 163 S.W.2d 109 (Mo. W.D. 1942), *abrogated on other grounds by Crall v. Hockman*, 460 S.W. 2d 668 (Mo. Banc 1970).

UNPAID MEDICAL BILLS

- Section 287.140 RSMo. Gives the employer right to select the treating physician.
 - NOT the insurer.
 - Employer must exercise that right. If not exercised, the right can be waived.
 - Exceptions for emergencies.
 - **See Banks v. Springfield Park Care Center

MEDICAL CARE – selection of treater

- Once an injury has been found to be compensable, the employer/insurer is **required** to provide medical care reasonably expected to cure and relieve the effects of the compensable injury and for any disabilities arising from the injury.
- Section 287.140.10 provides that it is the employer, not the insurer that has the right to select the treating physician. An employer cannot stand idly by while an employee selects the employee's own physician. The employer has the first opportunity of selection, this opportunity must be exercised. Medical treatment must be tendered by the employer before the employee's own selection can be considered an election to secure medical treatment at the employee's own expense.

Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. S.D, 1998),

- Here the employer had been made aware of a planned surgery, but did not take any control of the medical treatment by directing the claimant to an authorized physician. The court awarded the cost of unauthorized back surgery. The court held that, although an employer has the right to direct medical treatment, it is a right the employer must assert, and it can be waived if a demand was made for authorized treatment or the employer knew about the employee's need for treatment and either refuses to provide treatment." Id at 164 (quoting *Hackwell v. Purston-Bennett Corp.*, 901 S.W.2d 81, 85 (Mo. App. E.D. 1995)).

Selection in Emergency

- If an emergency exists and it is impossible to obtain the services of a physician selected by the employer, the employee may make the employee's own selection. The fees and expenses incurred will be charged to the employer, if reasonable. **Schultz v. Great Am. Ins. Co., 103 S.W.2d 904 (Mo. App. W.D. 1937).**

TWO WAYS TO OBTAIN MEDICAL TREATMENT IN A DISPUTED CASE WHERE TREATMENT IS DENIED

- 1. Employee can seek a causation and treatment opinion and set the matter for a hardship hearing, OR
- 2. After denial, employee can seek treatment with a doctor of his or her own choosing and seek reimbursement at a hearing.

Hearing Where Past Medical Bills are at Issue

- To get award of past medical, employee must:
 - 1. Prove that a request for treatment was made and refused; and
 - 2. Testify as to the work-relatedness of the treatment.
 - A. Detail the medical expense
 - B. Testify that the medical expense is related to the work injury.

Employee's burden to Prove:

- **The employee must first prove that a request for treatment was made.**
- If an employer refuses to provide medical treatment, then the employer loses control over medical and the employee may seek reimbursement for related expenses at the hearing. **Martin v. Town & Country Supermarkets, 220 S.W.3d 836,844 (Mo. App. 2007)**

The employee may testify as to the work-relatedness of treatment.

- The employee has the burden to detail past medical expenses, testify to the relationship of the expenses to the compensable workplace injury and the continued liability to repay either the insurance carriers and/or the medical providers. **Farmer- Cummings v. Personnel Pool, 110 S.W.3d 818 (Mo. 2003)**. The employee also must show continued liability for the full amount of the medical bills. If there is a finding that the Claimant remains legally liable for the full amount of the bills, an award of the full amount of the charges is not a windfall, but compensation as provided by the Act. **Wiedower v. ACF Indus., Inc., 657 S.W.2d 71, 75 (Mo. App. E.D. 1983)**.

Farmer-Cummings Case

- Once employee proves past medical expenses are related to the work injury.
 - DEFENSES employer can raise:
 - 1. Employee was not required to pay the total bill
 - 2. Employee's liability for the rest of the bill has been extinguished;
 - 3. The reason her liability is extinguished is not due to a savings or insurance of the employee nor any benefits derived from any source other than the employer.

Esquivel v. Day's Inn of Branson and Cox Medical Center, 959 S.W.2d 486, 489 (Mo. App. 1998); *Shaffer v. St. John's Reg. health Ctr.*, 943 S. W. 2d 803, 808 (Mo. App. S.D.2008); *Porter v. Toys 'R' Us- Del, Inc.*, 152 S. W. 3d 310, 321 (Mo. App. W.D. 2004).

- Once the employee admits evidence of the medical bills and records and presents proof that the treatment was for the work-related injury, then the burden shifts to the employer and insurer to prove that the medical bills were unreasonable, unfair or not related to the injury.

- In **Farmer – Cummings at 819** the Commission reduced an award of \$175,000 in medical bills to \$110,000 because the bills reflected reduced charges and written off charges by the providers. The Court remanded the case for a determination of the claimant's continuing liability for any of the past medical expenses at issue”

Morris v. National Refractories & Minerals, 21 S.W.3d 866 (Mo. App. E.D. 2000),

Here, a collection action was brought based on the employers' non-tendering of the value of medical benefits totaling \$46,590. Awarded TTD and PPD had been paid but not the value of the medical services paid for by an employer funded group health insurance program.

The circuit court certified the worker's compensation award as a judgement in favor of the employee in the amount of the medical bills plus interest, the employee then attempted to execute on that judgement by garnishment. The court ultimately quashed the garnishment finding that the employer had paid the employee's bills through the company group medical plan and ordered the judgement satisfied upon the employer paying \$162.93, the balance due on the employee's medical bills. The Appellate court affirmed the finding of a credit of medical benefits paid under the company's group health policy.

Martin v. Mid-America Farm Lines, Inc., 769 S.W. 2d 105 (Mo. Banc 1989)

- In **Martin**, the employee testified that the visits to the hospital and to the physicians were a product of a fall at work and further stated that the bills were received for those visits.
- The Court held that when such testimony accompanied the bills a sufficient factual basis exists to award payment of the bills.

Settlement Strategies for Cases with Unpaid Medical Bills

- Depends on who paid the bills
- 1. If bills were paid by employer's self-funded ERISA plan, employer has power to negotiate repayment to the plan.
 - Employee's out-of-pocket expenses as well.
 - A hold harmless agreement should be included in the settlement paperwork.

Settlement Strategies for Cases with Unpaid Medical Bills

- 2. If employee paid the bills himself, with the assistance of an insurance policy that is not provided by employer
 - A. Find out if employee must reimburse the plan (see below discussion on ERISA)
 - B. Employer should consider reimbursing employee for everything they may owe.

RESPONSIBILITY for MEDICAL BILLS:

- Section 287.140.3 provides:
 "All fees and charges under this chapter shall be fair and reasonable, shall be subject to regulation by the division or the commission, or the board of rehabilitation in rehabilitation cases. A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service is a private individual or a private health insurer carrier..."

Curry v. Ozarks Electric Corp., 39 S.W. 3d 494 (Mo. Banc 2001)

- the authorized medical care provider had provided authorized medical services but had not been paid. A notice of claim for direct payment per section 287.140.13(6) was filed. The employee and employer/insurer settled the claim leaving open the direct payment claim. The Commission awarded \$106,000 in authorized medical bills.
- The Court of Appeals overruled, stating the Commission was without jurisdiction to order the bill payment because the approval of the compromise lump-sum settlement ended the Commission's jurisdiction over all related claims.
- The Supreme Court disagreed. It held that the Commission had the power to bifurcate the settlement proceedings between the claimant and the employer/insurer and the direct payment claim.

FUTURE MEDICAL CARE

- The Claimant has the burden in proving the need for future medical benefits. The claimant need not show "conclusive evidence" of a need for future medical treatment. **Stevens v. Citizens Memorial healthcare Foundation, 244 S.W.3d at 237** (quoting **ABB Power T & D. Co. v Kempker, 236 S.W.3d 43, 52 (Mo. App. W.D. 2007)**). The claimant need only show "reasonable probability" that, the work related injury, future medical treatment will be necessary. A claimant need not show evidence of the specific nature of the treatment required.

Future Medical Care

- **Standard of Proof – Reasonable Probability**
- A claimant need not show "conclusive evidence" of a need for future medical treatment. **Dean v. St. Luke's Hospital, 936 S.W. 2d 601 (Mo. App. W.D. 1997)**, *overruled on other grounds by Hampton v. Big Boy Steel. Erection, 121 S.W. 3d 220 (Mo. Banc2003)*; **Stevens v. Citizens Memorial Healthcare Foundation, 244 S.W.3d at 237** (quoting **ABB Power T & D Co. v Kempner, 236 S.W. 3d 43, 52 (Mo. App. W.D. 2007)**). A claimant need only show evidence of the specific nature of the treatment required. **Tillotson v. St. Joseph Med. Ctr., 347 S.W.3d 511 (Mo. App. 2011)**; **Mathia v. Contract Freighters, Inc., 929 S.W.271, (Mo. App. S.D. 1996)**

FUTURE MEDICAL CARE

- **Commission cannot substitute personal opinion for that of uncontracted medical expert.**
- In **Tillotson, supra 525**, the court held that the medical testimony that the claimant's compensable injury (and related required medical care) would require the need for future medical care was *an uncontroverted medical causation opinion*. This opinion was not rejected as not credible.

FUTURE MEDICAL CARE

- **Once the medical causation of injury is proven: medical care & treatment reasonably required to cure and relieve the compensable injury: "prevailing factor" does not apply.**

- In *Tillotson* at 525, Court held that after the Commission found that the claimant had suffered a compensable injury, then the employer/insurer were required to award her compensation for medical care and treatment reasonably required to care and relieve her compensable injury, and for the disabilities and future medical care naturally flowing from the reasonably required medical treatment. Because the uncontested medical evidence established that a total knee replacement was reasonably required to treat Tillotson's torn lateral meniscus, the claimant is entitled to recover the cost of the knee replacement surgery, total disability during the recuperative period following the total knee replacement, for permanent partial disability resulting from the total knee replacement, and for future medical expenses necessitated by the total knee replacement.

- **Hornbeck v. Spectra Painting, Inc. 370 S.W.3d 624, 633-634 (Mo. 2012)** reaffirmed the principle that **there is no prevailing factor test** for proving that treatment is compensable.
- See **Malam v. Missouri Department of Corrections**, pending in MO Supreme Court 2016.

ERISA –What is it and why do we care?

- ERISA—Employee Retirement Income Security Act of 1974.
 - Governs all employee benefit plans, except federal, state and government plans. Those types of plans are governed by FEHBA or by 376.433.1 RSMo.
 - Important because it pre-empts state laws that relate to employee benefit plans, except those that regulate the business of insurance.
 - ++Plans funding through insurance are subject to state regulations, while plans funded through the assets of the employer are not subject to state regulation.

ERISA—What is it and why do we care?

- Any plan provided by an employer may be an ERISA plans, but insured plans are subject to Missouri’s anti-subrogation law, while self-funded employer plans are not.
 - Practicality—reimbursement provisions in an employer self-funded plan are enforceable, but reimbursement provisions in an insured plan is not.

ERISA—When do we care?

- IF a plan pays the employee’s bills and is seeking reimbursement.
 - Union plans
 - Spouse’s or parent’s plans
 - Secondary plans**These plans are not provided by the employer who is subject to the workers’ compensation claim.

AFTER DETERMINING A PLAN IS SELF-FUNDED ERISA PLAN

- Determine employee's out-of-pocket expense
- Determine amounts paid by plan
 - Ask client to print out EOBs and review.
 - Look at bills themselves
 - Ask for payment detail from subrogation company.

Social Security Disability Offset & Medicare Issues

Needs-Based vs Entitlement programs

- Needs-Based Programs: Supplemental Security Income – Title XVI

MO Health Net- Title XIX
HUD- housing assistance
Food Stamps

Entitlement Programs: Disability Insurance Income- Title II

Retirement Income Benefits
Medicare, Part A

To qualify for Supplemental Security Income (‘SSI) benefits, the maximum is \$2,000 in available resources.

Other “ needs-based” programs have differing eligibility requirements, some are based on amount of income, some on amount of available resources, some have elements of both income and resources.

SS offset – 42 U.S.C. 424a(1)(6) and 20 C.F.R. 404.408 (a) –©(2)

- These sections provide a dollar for dollar offset of an individual's DIB (disability benefit) in any month in which the number of dollars that an individual receives from a combination of workers compensation and DIB exceeds either:
80% of the individual's ACE (average current earnings)
OR
The total benefits to which the individual and the individual's family are entitled each month as a result of the disability,
Whichever is higher.

- NOTE: The offset calculation is a one time, snapshot taken in the 1st month in which it can be determined that an individual was entitled to receive both WC & DIB. (POMS DI 520001-001(2)).
- 42 USC 424(a) has not been amended to reflect the incremental increase in the full retirement age from 65 to 67. It is presumed that the offset provisions will stop at age 65 even though an individual has not reached their full retirement age for their birth year.

OFFSET FORMULAS

- 42 USC 424(a) (8) establishes 3 distinct methods for determining individual's average current earnings (ACE). The law provides that the method to be used in any given case is the one that is most favorable to the beneficiary.
- The 3rd method takes the calendar year in which a worker had the highest wages during the preceding 5 years from the date he/she became disabled. 80% of the workers ACE are the total # of dollars the worker can receive each month from a combination of WC benefits & DIB.

WC Benefits included in offset calculations:

- Temporary Total
- Permanent Partial
- Permanent Total benefits

WC Benefits NOT included in Offset Calculation:

- Past & Future Medical Benefits
- Legal fees & Costs
- Interest –(POMS DI 52001.075)
- Penalty Benefits – (POMS DI 52001.75)
- Death Benefits (Burial)
- Rehabilitation Benefits
- Money received by a 3rd Party settlement or lawsuit (POMS DI 52001-090)

EXHIBIT A

EMPLOYEE : _____ **Injury Number** _____
SSN: _____
EMPLOYER: _____
INSURER: _____

- IN SETTLEMENT OF THE ABOVE LISTED INJURY, THE EMPLOYEE AGREES TO ACCEPT AND THE EMPLOYER AGREES TO PAY, A LUMP SUM OF \$ _____.
- THE LUMP SUM IS COMPENSATION FOR PERMANENT PARTIAL DISABILITY THAT WILL AFFECT THE EMPLOYEE FOR THE REST OF THE EMPLOYEE'S LIFE, PURSUANT TO SECTION 237-250.9 R.S.Mo.
- THE EMPLOYEE WAS BORN ON _____ AND IS _____ YEARS OLD. THE EMPLOYEE'S LIFE EXPECTANCY AT THIS AGE IS _____ YEARS OR _____ MONTHS. THEREFORE, EVEN THOUGH THIS SETTLEMENT IS PAID IN A LUMP SUM, AFTER ATTORNEY'S FEES OF 25% THE EMPLOYEE'S BENEFITS SHALL BE CONSIDERED TO BE \$ _____ A MONTH FOR _____ MONTHS BEGINNING _____.

ADMINISTRATIVE LAW JUDGE DATE

Definitions:

- **Date of Onset:**
The date an individual is found disabled.
- **Date of entitlement:**
This is the 1st month an individual is entitled to receive DIB. There is a 5 month waiting period from date of onset to date of entitlement in which no DIB are paid. 42 USC 423(c) (2). DIB is retroactive for 1 year prior to date of disability application.

Definitions:

- **SSI/Title XIV:**
Benefits are based on medical disability and financial considerations.
There is no 5 month waiting period for SSI benefits, which begin w/ the date of application or date of disability if found after date of application.
- **COLA (Cost of Living Increases):**
DIB levels are adjusted in accordance with the Consumer Price Index published by the Bureau of Labor each year.

The annual COLA adjustments are NOT affected by WC benefits in the offset calculations

Definitions

• **Trial Work Period:**

SSA does provide for a period of trial work for 9 months in which an individual may earn any amount of \$ during a rolling 60 month period and still receive DIB. 42 USC 422(c); 20 CFR 404.1592

• **Substantial Gainful Employment (SGA):**

The law does allow people who are receiving DIB to earn wages each month, as long as the amount does not exceed the current SGA threshold which is \$1090.00 a month. (The amounts are higher for the Blind)

EARLY RETIREMENT:

- Individuals can elect to take early retirement benefits anytime after age 62. While this means a reduced benefit, the early retirement benefits are not offset by the WC benefits. Disabled individuals who switch from receiving DIB to early retirement benefits also do not lose their Medicare benefits.

Auxiliary Benefits:

- 42 USC 402(d) (2) provides that the children of a disabled individual are entitled to receive a monthly benefit which is approximately 1/2 of the disabled parents DIB. This is divided evenly among dependents until age 18 or 19 if still a full time student in an elementary or secondary school.

If there is a WC offset, it reduces the Auxiliary Benefits 1st before reducing the benefits of a worker.

MEDICARE ISSUES:

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- **Medicare Secondary Payer Provisions**
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- Medicare is a health insurance program that was established in 1965 under Title XVIII, 42 U.S.C. §§ 1395 *et. Seq.*, of the Social Security Act. Individuals who receive Social Security title II benefits for 24 months or railroad retirement benefits and workers over the age of 65 are entitled to Medicare. The CMS, an agency of the U.S. Department of Health and Human Services, has responsibility for administering the program.

Medicare Coverage

- The Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, 79 Stat. 290, allows for coverage when services received are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A).
- Medicare coverage excludes by statute custodial care, except in the case of hospice services. 42 U.S.C. § 1395y(a)(9). Specific Medicare coverage questions can be addressed by calling 1-800/medicare (1-800/633-4227) or by visiting:
- www.cms.gov

Medicare Secondary Payer and Workers' Compensation

- The regulations that provide guidance in dealing with Medicare payments for services covered under workers' compensation begin at 42 C.F.R. § 411.40 in Subpart C. In general, the provisions of the Medicare Secondary Payer provide that Medicare does not pay for services for which payment has been made or can reasonably be expected to be made promptly "under a workmen'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 no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(i) and (ii). A Claimant has a duty to file a workers' compensation claim. 42 C.F.R. § 411.43(a). If there is a failure to pursue a workers' compensation claim, Medicare will not pay for services that would have been covered under workers' compensation. 42 C.F.R. § 411.43(c).

Conditional payments

- Medicare will make a conditional payment on medical expenses related to a workers' compensation claim if the insurance carrier or self-insured employer has failed to timely pay or has denied payment. 42 C.F.R. § 411.45(a). Because the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. no. 108-173, 117 Stat. 2066, removed the word "promptly," probably Medicare will only pay if there is a clear denial on the part of the workers' compensation carrier or if the claimant is unable to file a claim because of a physical or mental incapacity. 42 C.F.R. § 411.45(b). Medicare will pay medical expenses in a workers' compensation case if the treatment was not authorized by the insurance carrier. 42 C.F.R. § 411.40(b)(2).

COMMUTATION & COMPROMISE SETTLEMENTS

- Two types of workers' compensation lump-sum payments are defined at 42 C.F.R. § 411.16:
 1. **commutation settlement** - agreement that is intended to compensate an individual for all future medical expenses.
 2. **compromise settlement**- occurs when a payment is made to settle a case even if there is no a liability under a workers' compensation law.

- Medicare will examine compromise settlements carefully to make sure that there is no attempt to shift to Medicare the responsibility of medical expenses. 42 C.F.R. § 411.46(b)(2). **If Medicare concludes that future medical care was improperly addressed in the settlement, it will not pay for treatment of that condition.**

Rules for Medicare to evaluate a compromise settlement that fails to apportion payments for future medical expenses and to repay Medicare for past conditional payments that were not paid at the time of the settlement are located in 42 C.F.R. §411.47.

WCMSA:

- A WCMSA is not necessary when resolution of the workers' compensation claim leaves the medical aspects of the claim open.

WCMSA

- A WCMSA should be submitted to the CMS for review in the following situations:
 1. The Claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000.00.or
 2. The Claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.00.

- if Medicare pays bills that it finds related to a workers' compensation settlement when there was insufficient consideration of its interests, **Medicare can set off that overpayment by withholding payment on other non-work-related claims until the funds or overpayment is recovered.**

MEDICAID

Known as "Missouri Healthnet."

- Need- based program administered by the Department of Social Services
- Medicaid is payer of last resort, but Sec. 208.215.13 RSMo. Specifically states provisions do not apply in workers' compensation cases.
- ****NOTE ON GOVERNMENTAL PLANS DISCUSSED ABOVE:**
 - Section 376.433. 1. Any public entity which provides, furnishes, or pays for hospital, medical, surgical, or other health care services under a plan of self-insurance to an employee or to any other person covered under the public entity's plan of self-insurance shall have the same rights and obligations, and be subject to the same remedies, as the department of social services has with Medicaid, as provided in section 208.215.

MEDICAID

- INSTEAD, PAY ATTENTION TO 287.266:
- 2. Payments made to or on behalf of a person eligible for public assistance as the result of any compensable injury, occupational disease or disability as defined by this chapter shall be a debt due the state, and recovery of same shall be a recognized action pursuant to this chapter.
- 3. The state shall have a lien upon any funds owed by any employer that are or might be due under any insurance agreement or self-insurance authority in effect at the time the medical expense or any portion thereof was paid by the department of social services or its designated division.
- 287.266 RSMO

MEDICAID

- 287.266.9—counsel should notify Mo HealthNet of a client who has a workers compensation claim and is eligible for and receiving benefits. Must notify them of your representation for the specific injury
- Mo Healthnet will inform you of the amounts they pay for a particular injury and the amount of their lien.

MEDICAID

- 287.266.10 give the ALJ authority to apportion the debt due the state between the injured worker and the employer/insurer
- BUT ALJ has no power to reduce the debt as the circuit judge does in civil cases under 208.215

MEDICAID

- To notify Medicaid, send a medical release and a letter, informing them of your representation, including date and nature of the injury, to:

Missouri Dept. of Social Services
Mo Healthnet Division
PO Box 6500
Jefferson City, MO 65102-6500
