

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
DIVISION FOR PROGRAM INTEGRITY

# Casualty Recovery Procedure Manual

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Third Party Liability Branch

December 2016

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## Initial Case Set-Up by the Fiscal Agent

- An attorney must submit a letter of representation including: the Member's Medicaid ID/SSN, date of injury, complete list of injuries sustained. A letter of representation must be on file in order to discuss case information with an attorney.
- Claim totals are run based on accident-related injuries, therefore a list of injuries needs to be in writing, and as complete and specific as possible.
- The letter from the attorney must include all necessary contact information.
- Obtain a copy of the retainer agreement.
- An attorney must submit a HIPAA compliant medical release signed by the member or their responsible party in order to receive any Medicaid member documentation.
- Attorneys are notified of Medicaid's subrogation claim and right of recovery in writing (Letters will need to state that the claim amount does not include amounts that may have been paid under a Managed Care Organization). Also Kentucky Medicaid Providers have one (1) year from the date of service to bill, so that amount is subject to change. (See *K.R.S. 205.520* and *K.R.S. 205.624* – Attached).
- If there are zero accident related paid claims for a case, the attorney will be notified in writing that Medicaid does not currently have a claim related to the accident, but Kentucky Medicaid Providers have one (1) year from the date of service to bill Medicaid, so that amount is subject to change.
- An attorney may have up to 30 days to respond to the first letter. If no response is received after 30 days, then a second letter should be sent by certified mail.

## MCO Subrogation Claims

If the date of accident is 11/1/2011 or later, and the member was covered under a managed care organization (MCO), the attorney will be notified and referred to the appropriate MCO for assistance with their subrogation inquiry.

### **Aetna Better Health (formerly CoventryCares of Kentucky)**

Name: Josh Holmberg  
Address: First Recovery Group  
26899 Northwestern Hwy, Suite 250  
Southfield, MI 48033  
Member Services Manager  
Email: [referrals@firstrecoverygroup.com](mailto:referrals@firstrecoverygroup.com)  
Phone: (877) 449-4803  
(800) 877-6876  
Fax: (248) 443-4804

### **Anthem Health Plans of Kentucky**

Name: Anthem Kentucky Medicaid  
Attn: Cost Containment Unit  
Fax: (888) 393-8993

### **Humana CareSource**

Address: Attn: Legal Department  
230 North Main Street,  
Dayton, OH 45402  
Fax: (800) 605-0137  
Email: [SubrogationRecovery@caresource.com](mailto:SubrogationRecovery@caresource.com)

### **Passport Health Plan**

Name: Tonya Appleby  
Address: Passport Health Plan  
5100 Commerce Crossings Drive  
Louisville, KY 40229  
Email: [Tonya.Appleby@passporthealthplan.com](mailto:Tonya.Appleby@passporthealthplan.com)

**WellCare of Kentucky**

Name: Josh Holmberg  
Address: First Recovery Group  
26899 Northwestern Hwy, Suite 250  
Southfield, MI 48033  
Member Services Manager  
Email: [referrals@firstrecoverygroup.com](mailto:referrals@firstrecoverygroup.com)  
Phone: (877) 449-4803  
(800) 877-6876  
Fax: (248) 443-4804

**Accident/Subrogation- HP Enterprise Services (HPES)  
((Medicaid Fee for Service))**

Kentucky Medicaid Recovery  
HP Enterprise Services, TPL Unit  
Address: P.O. Box 2107  
Frankfort, KY 40602  
Phone: 1-800-807-1459

## Follow Up Procedures

- Attorneys can request for a case to be revalued. When there is a change to the claim total, the attorney will be notified in writing of the updated total, even if they have already been contacted by phone.
- Attorneys will be requested to submit updated medical HIPAA releases as needed.
- Attorneys should receive an inquiry letter as to the status of litigation every ninety (90) days.

If a case has been transferred to the Cabinet's Office of Legal Services (OLS) the attorney must contact OLS to request any additional information or to submit additional information.

## Release of Information

The fiscal agent must have a HIPAA compliant medical release on file in order to release itemized claims. The release should specify what type of information can be released, the party it can be released to, and it should have an expiration date. Please make sure ALL fields on the release are complete prior to submitting.

## Cost Effectiveness Threshold

At the initial case set-up, if a case total is below \$250:

The attorney will receive a letter advising them that the case total is currently under the threshold for collection. The letter will also state that Kentucky Medicaid Providers have one (1) year from the date of service to bill Medicaid, therefore the case will be re-valued prior to settlement and the case will remain open.

If the case has settled/is in the process of settling, and the attorney has requested closure due to a total less than \$250.00:

- The fiscal agent will request an update of the total to verify that no additional claims have paid.
- The case information is then sent to DMS for approval to close the case. A form will be sent to HP for inclusion in the case file.
- The attorney will receive a letter informing them that since the claim amount is less than \$250.00, pursuant to Attachment 4.22-A of the Kentucky State Plan, Requirements for Third Party Liability, Identifying Liable Resources, DMS does not consider it cost effective to pursue the claim.

In order to approve closure on a case, DMS must have confirmation of settlement and verification that the total provided is the updated total.

Once this information has been received, the form will be filled out and returned to HP.

### Removal of Unrelated Claims

- When an attorney is requesting to remove unrelated claims, he/she must submit medical records to document why the claims were not related to the accident. Sufficient documentation must be provided to show why the claims are not related. If satisfactory documentation has been provided, the appropriate claims may be removed from the total.
- If an attorney is disputing a portion of a claim (with multiple diagnosis codes), please advise them that it is their responsibility to contact the provider for further information/documentation on the portion of the claim total that relates to each diagnosis code. DMS will not “split” or re-price claims for claims removal requests. Further, if the claim is a hospital claim, due to hospital billing procedures, those claims cannot be re-priced.
- If a case has been transferred to the Cabinet’s Office of Legal Services, please send all claims removal requests to DMS.
- When claims are removed, please inform all parties in writing of the updated claim amount.

### Reduction/Waiver Requests

DMS requires the following information for consideration of case reduction or case waiver requests. Reduction/waiver requests will not be considered until all information is received.

- Updated Claim Total
- Case Settlement Agreement
- Retainer Agreement
- If available, an itemization of case costs
- Copy of Letter of Protection
- Copy of initial letter of representation
- Member status (Medicaid active or discontinued)
- If there is an MCO claim, DMS must know: A) What the MCO claim amount is, B) The amount (if) any that the MCO has been asked to reduce their claim, and C) If the MCO has agreed to the reduction
- Overview of case (extent of injuries, current/future hardship due to injuries, causation between the accident and the injuries etc.). This account should be as detailed as possible and included with every request.

If an attorney is requesting a waiver or reduction due to pre-existing conditions, or lack of proof that the accident caused the alleged injuries, the attorney will need to submit medical documentation to verify the pre-existing condition(s) and/or lack of causation. In these situations, the overview of the case must include a summary of the pre-existing conditions or reasons why the injuries cannot be attributed to the accident.

If an attorney is not willing to provide the settlement agreement or retainer agreement, they will be advised that their request for reduction will not be considered until that information is submitted.

If asked for the reason for documentation when requesting a reduction/waiver, please provide the following response:

*All Medicaid subrogation cases are subject to audit from the Centers for Medicare and Medicaid Services. As such, the Department has made it a standard part of the case process to request settlement documentation for all reduction requests. This documentation is necessary to demonstrate that the Department performed its due diligence in evaluating requests for reduction of subrogation claim amounts.*

DMS will inform the fiscal agent once a determination has been made on a reduction request. HP staff will let the attorney know of Medicaid's decision.

## Attorney Fees

### Attorney Fee Reduction

Under KRS 205.626(3), "The attorney may receive a percentage not to exceed twenty-five percent (25%) of the amount paid to the cabinet that has been recovered in reimbursement from the third party." This is an attorney fee reduction, not a reduction in Medicaid's claim amount.

For an attorney fee reduction to be considered the following must occur:

- For a fee to be considered, a letter of protection (LOP) must be received with his/her initial response to Medicaid's claim letter. Further, in order to be valid, an LOP must be on file prior to settlement of the case. If there is not a valid LOP on file prior to settlement, the attorney is not eligible to receive a fee from Medicaid's portion of the settlement.
- The fee is not an automatic 25% percent (refer to statute). Once the attorney has reached an agreement with DMS, and there is a valid LOP on file, determinations will be made on a case-by-case basis, of what percentage, if any, DMS will allow for an attorney fee.

Requests for the attorney fee reduction will be sent by the fiscal agent to DMS and the following must be included:

- Medicaid's updated claim total
- The amount Medicaid will receive from the settlement
- Letter of Protection
- Settlement agreement
- Retainer agreement



If an attorney inquires as to why the documentation is required for the attorney fee reduction, please provide the following explanation:

*All Medicaid subrogation cases are subject to audit from the Centers for Medicare and Medicaid Services. As such, the Department has made it a standard part of the case process to request settlement documentation for all reduction requests, including attorney fee reductions. This documentation is necessary to demonstrate that the Department performed its due diligence in evaluating requests for reduction of subrogation claim amounts.*

### Contractual Attorney Fees

Attorneys must be made aware that pursuant to KRS 205.626(3), “The amount paid to the Cabinet shall be excluded by the attorney when computing the total amount recovered on behalf of the client and in final computation of the client’s bill.”

Medicaid’s full claim amount should be deducted first from the total settlement amount. The attorney should calculate their contingency fee based on the amount remaining after Medicaid’s portion has been taken off of the total.

A copy of the KRS 205.626 is included for your reference at the end of this guide

### Talking Points- KRS 205.626

The talking points are written in an example question and answer format based upon situations that recovery staff may encounter during calls with attorneys.

Under KRS 205.626(3), “The attorney may receive a percentage not to exceed twenty-five percent (25%) of the amount paid to the cabinet that has been recovered in reimbursement from the third party.”

Q: “I used to get 25% for all my Medicaid cases, why the change? And how much will I receive now?”

A: “If you refer to KRS 205.626(3), the statute states that, “the attorney may receive a percentage not to exceed twenty-five percent.” Pursuant to the statute, the twenty-five percent fee is not guaranteed. Requests for the attorney fee reduction will be evaluated on a case-by-case basis once an agreement has been reached with Medicaid on a settlement of the Department’s claim.”

Q: “I got Medicaid \$10,000.00 out of its \$90,000.00 claim against a \$100,000.00 settlement, why was I only granted 10% as an attorney fee reduction?”

A: “A major factor taken into consideration when evaluating attorney fee reduction requests is the amount that Medicaid actually received in proportion to its full claim amount and the settlement as a whole.”

Under KRS 205.626(3), “The amount paid to the Cabinet shall be excluded by the attorney when computing the total amount recovered on behalf of the client and in final computation of the client’s bill.”

Q: “I have a case where Medicaid paid \$20,000.00, the case settled for \$40,000.00 and my contractual fee is 40%, so do I deduct my fee, pay Medicaid, and then the Medicaid recipient receives the amount left?”

A: “No. According to KRS 205.626(3), Medicaid’s claim amount is deducted from the settlement total first, and then any contingency fee is calculated based upon the remaining amount.”

Q: “Why is Medicaid telling me how to calculate my fee? What gives you the authority?”

A: “KRS 205.626(3) requires that Medicaid’s subrogation amount be excluded from the settlement amount when the contingency fee is calculated. By requiring you to deduct the amount paid to Medicaid first, and calculate your contractual fee based upon the remainder, the Department is following the statute.

### Special Needs Trusts

If an attorney wishes to place settlement proceeds into a Special Needs Trust (SNT) for their client, please inform them of the following:

- Medicaid’s subrogation claim must be satisfied prior to placing any settlement funds in trust for the member.
- The SNT must be submitted to the member’s DCBS caseworker or to the Social Security Administration to be sent to Medicaid for approval. If the attorney has any questions regarding SNTs, please refer them to the DMS Eligibility Policy Branch at (502)564-6204.

### Subpoenas/Interrogatories

If HP receives a subpoena or set of interrogatories related to litigation on a casualty case, that information should be forwarded to DMS immediately.

## Transferring Cases to the Office of Legal Services

Cases with the following criteria should be sent to DMS for OLS transfer immediately:

- When Medicaid is asked to assert its subrogation rights by intervention in the legal action.
- Any action in which the Department for Medicaid Services is named as a party.
- If an attorney states that settlement proceeds should be allocated under the decision in Arkansas Department for Health and Human Services v. Ahlborn.
- Any case involving a nursing home resident and a wrongful death action.
- Cases in which the settlement proceeds have been distributed and the attorney did not notify Medicaid of the legal action and possible subrogation interest as they are required to do so under *K.R.S. 205.629*.

## Case Closure/Settlement

When payment is received, send a closure letter to the attorney acknowledging that payment has been received.

Apply the payment to the case on MMIS and close the case.

## Settlement Reports

DMS reports settlements received by Medicaid members to the Social Security Administration (SSA) and the Department for Community Based Services (DCBS). At the end of each month, please prepare a report of settlements received by members that includes the following information:

- Member Name
- SSN
- Settlement Date
- Settlement Total
- Amount Received by DMS
- Amount Received by Member
- Date Settlement Received by Member

When requesting the information, please contact the attorney by telephone to explain what is needed, and follow up by sending the settlement release of information letter to the attorney either by fax or mail.

Please refer attorneys with questions/concerns regarding this process to DMS at (502)564-4958.

## References

K.R.S. 205.624 Assignment to cabinet by recipient of rights to third-party payments -- Right of recovery by cabinet.

(1) An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third-party payments to the extent of medical assistance paid on behalf of the recipient under Title XIX of the Social Security Act. The applicant or recipient shall be informed in writing by the cabinet of such assignment.

(2) The cabinet shall have the right of recovery which a recipient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions of Title XIX of the Social Security Act.

(a) If a payment for medical assistance is made, the cabinet, to enforce its right, may:

1. Intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court; or

2. Institute and prosecute legal proceedings against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors; or

3. Institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors.

(b) The injured, diseased, or disabled person may proceed in his own name, collecting costs without the necessity of joining the cabinet or the Commonwealth as a named party, provided the injured, diseased, or disabled person shall notify the cabinet of the action or proceeding entered into upon commencement of the action or proceeding. The injured, diseased, or disabled person must notify the cabinet of any settlement or judgment of his or her claim.

(c) In the case of an applicant for or recipient of medical assistance whose eligibility is based on deprivation of parental care or support due to absence of a parent from the home, the cabinet may:

1. Initiate a civil action or other legal proceedings to secure repayment of medical assistance expenditures for which the absent parent is liable; and
2. Provide for the payment of reasonable administrative costs incurred by such other state or county agency requested by the cabinet to assist in the enforcement of securing repayment from the absent parent.
- (3) Each insurer issuing policies or contracts under Subtitle 17, 18, 32, or 38 of KRS Chapter 304 shall cooperate fully with the Cabinet for Health and Family Services or an authorized designee of the cabinet in order for the cabinet to comply with the provisions of subsection (1) of this section.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 247, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 205, effective July 15, 1998. -- Amended 1994 Ky. Acts ch. 96, sec. 18, effective July 15, 1994; and ch. 316, sec. 18, effective July 15, 1994. -- Created 1980 Ky. Acts ch. 252, sec. 4, effective July 15, 1980

K.R.S. 205.520 Title and purpose of KRS 205.510 to 205.630 -- Recovery from third parties for services rendered.

- (1) KRS 205.510 to 205.630 shall be known as the "Medical Assistance Act."
- (2) The General Assembly of the Commonwealth of Kentucky recognizes and declares that it is an essential function, duty, and responsibility of the state government to provide medical care to its indigent citizenry; and it is the purpose of KRS 205.510 to 205.630 to provide such care.
- (3) Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.
- (4) It is the intention of the General Assembly to comply with the provisions of Title XIX of the Social Security Act which require that the Kentucky Medical Assistance Program recover from third parties which have a legal liability to pay for care and services paid by the Kentucky Medical Assistance Program.
- (5) The Kentucky Medical Assistance Program shall be the payor of last resort and its right to recover under KRS 205.622 to 205.630 shall be superior to any right of reimbursement, subrogation, or indemnity of any liable third party.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 228, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 195, effective July 15, 1998. -- Amended 1982 Ky. Acts ch. 248, sec. 1, effective July 15, 1982. -- Amended 1980 Ky. Acts ch. 188, sec. 124, effective July 15, 1980; and ch. 252, sec. 2, effective July 15, 1980. -- Amended 1979 (1st Extra. Sess.) Ky. Acts ch. 2, sec. 8, effective February 10, 1979. -- Amended 1974 Ky. Acts ch. 74, Art. VI, sec. 107(1), (15), (16) and (19). -- Amended 1966 Ky. Acts ch. 134, sec. 6. -- Created 1960 Ky. Acts ch. 68, Art. VII, secs. 1 and 2.

K.R.S. 205.626 Time assignment becomes enforceable -- Payment to cabinet -- Attorney's fees.

(1) The assignment provided for by KRS 205.624 shall be binding and enforceable after the third parties have actual notice of the assignment. The third party shall be discharged from liability under the assignment when it makes payment to a vendor for medical care and services rendered on behalf of a recipient.

(2) Any settlement, judgment, or award obtained by a recipient or the recipient's legal representative against a third party is subject to the cabinet's claim for reimbursement for medical assistance paid on behalf of the recipient.

(3) The attorney may receive a percentage not to exceed twenty-five percent (25%) of the amount paid to the cabinet that has been recovered in reimbursement from the third party. The amount paid to the cabinet shall be excluded by the attorney when computing the total amount recovered on behalf of the client and in final computation of the client's bill.

Effective: July 15, 1994

History: Amended 1994 Ky. Acts ch. 506, sec. 1, effective July 15, 1994. -- Created 1980 Ky. Acts ch. 252, sec. 6, effective July 15, 1980.

K.R.S. 205.623 Information on claims paid for insurance policyholders and dependents -- Use of data -- Confidentiality of information -- Prohibited fees.

(1) All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the Department for Medicaid Services, by electronic means and in the format prescribed by the department, policy and coverage information and claims paid data on Medicaid-eligible policyholders and dependents. Any request from the department shall include a list of data elements that shall be included on the electronic file from the insurer or administrator.

(2) All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the department, by electronic means and in the format prescribed by the department, identifying information on all policyholders and dependents to match with the Medicaid management information system to determine which policyholders and dependents also participate in the Kentucky Medical Assistance Program. The identifying information shall include the name, address, date of birth, and Social Security number as these items appear in the companies' files and as the department may require.

(3) No health insurer or administrator shall be required to provide information under this section if doing so would violate any provision of federal law.

(4) All information obtained by the department pursuant to this section shall be confidential and shall not be open for public inspection.

(5) The department shall not be charged a fee by a third party for information requested under this section, nor shall the department be charged a fee by a third party for the processing and adjudication of the department's claim for recovery, reclamation, or validation of eligibility.

Effective: July 15, 2008

History: Amended 2008 Ky. Acts ch. 71, sec. 5, effective July 15, 2008. -- Amended 2005 Ky. Acts ch. 99, sec. 246, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 204, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 353, sec. 5, effective July 15, 1996. -- Created 1994 Ky. Acts ch. 506, sec. 5, effective July 15, 1994.