

## **X.Q. Third Party Liability (TPL) and Worker's Compensation (WC)**

The State of California has retained the right of recovery for all TPL and WC cases involving Medi-Cal recipients including Medi-Cal members enrolled in the PHC program. Attached is a copy of the Welfare and Institutions Code (Article 3.5: Third Party Liability).

When a provider becomes aware of third party liability, the following steps are to be followed:

1. Notify the State immediately at (916) 650-0490 (TPL Unit for PHC Members).
2. Submit claims to PHC, all Plan provisions will apply. RAFs and TARs must be obtained for required services.
3. If a provider is approached, **do not** provide any claims data to any other insurance carrier or attorney. Submit copy of Letter of Request to TPL Unit and refer all calls or inquiries to that unit:

Personal Injury Unit  
MS 4720  
Department of Health Care Services  
P.O. Box 997425  
Sacramento CA 95899-7425

**ARTICLE 3.5. Third Party Liability [14124.70 - 14124.94]**

( Article 3.5 added by Stats. 1976, Ch. 621. )

**14124.70.**

As used in this article:

(a) "Carrier" includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) "Beneficiary" means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary's guardian, conservator or other personal representative, his estate or survivors.

(c) "Reasonable value of benefits" means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

(d) "Lien" means the director's claim for recovery, from a beneficiary's tort action or claim, of the reasonable value of benefits provided on behalf of the beneficiary.

*(Amended by Stats. 2007, Ch. 188, Sec. 70. Effective August 24, 2007.)*

**14124.71.**

(a) When benefits are provided or will be provided to a beneficiary under this chapter because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Insurance Code Section 11580.2, the director shall have a right to recover from such person or carrier the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal program with the permission of the Attorney General, or a contractor pursuant to Section 14124.80, or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury in an

appropriate court, either in the name of the director or in the name of the injured person, his guardian, conservator, personal representative, estate, or survivors.

(b) The director may:

(1) Compromise, or settle and release any such claim, or

(2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(c) No action taken in behalf of the director pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, conservator, personal representative, estate, dependents, or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(d) The cost of a service provided to an eligible developmentally disabled Medi-Cal beneficiary under Section 14132.44 may be recovered by the director from a liable third person or an insurance carrier.

*(Amended by Stats. 1988, Ch. 1280, Sec. 2.)*

#### **14124.72.**

(a) Where an action is brought by the director pursuant to Section 14124.71, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section 14124.71.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's right to recover from that party the reasonable value of the benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d).

(d) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the reasonable value of benefits provided to the beneficiary under the Medi-Cal program less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the reasonable value of benefits so provided to the full amount of the judgment, award, or settlement.

*(Amended by Stats. 1998, Ch. 310, Sec. 100. Effective August 19, 1998.)*

#### **14124.73.**

(a) If either the beneficiary or the director brings an action or claim against such third person or carrier the beneficiary or the director shall within 30 days of filing the action give to the other written notice by personal service or registered mail of the action or claim, and of the name of the court or state or local agency in which the action or claim is brought. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the director or the beneficiary, the other may, at any time before trial

on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(b) If an action or claim is brought by the director pursuant to subdivision (a) of Section 14124.71, written notice to the beneficiary, guardian, conservator, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to obtain a private attorney of his choice, and the director's right to recover the reasonable value of the benefits provided.

*(Amended by Stats. 1979, Ch. 730.)*

#### **14124.74.**

In the event of judgment or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of the settlement, judgment, or award the reasonable value of additional benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d) of Section 14124.72, and as a second lien, the amount of any claims, pursuant to Section 14019.3, owed to a provider, as provided in Section 14124.791.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of these expenses and attorney's fees, the court or agency shall first apply out of the balance of the judgment or award an amount sufficient to reimburse the director the full amount of the reasonable value of benefits provided on behalf of the beneficiary under the Medi-Cal program, and then an amount sufficient to reimburse a provider who has filed a lien for any claims for services rendered to the beneficiary, as provided under Section 14124.791.

*(Amended by Stats. 1998, Ch. 310, Sec. 101. Effective August 19, 1998.)*

#### **14124.75.**

The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the reasonable value of additional benefits provided arising out of the same cause of action or claim provided on behalf of the beneficiary under the Medi-Cal Program, where such benefits were provided or became payable subsequent to the original order.

*(Amended by Stats. 1998, Ch. 310, Sec. 102. Effective August 19, 1998.)*

#### **14124.76.**

(a) No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be deemed final or satisfied without first giving the director notice and a

reasonable opportunity to perfect and to satisfy the director's lien. Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Absent the director's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary, the matter shall be submitted to a court for decision. Either the director or the beneficiary may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268 and other relevant statutory and case law.

(b) If the beneficiary has filed a third-party action or claim, the court where the action or claim was filed shall have jurisdiction over a dispute between the director and the beneficiary regarding the amount of a lien asserted pursuant to this section that is based upon an allocation of damages contained in a settlement or compromise of the third-party action or claim. If no third-party action or claim has been filed, any superior court in California where venue would have been proper had a claim or action been filed shall have jurisdiction over the motion. The motion may be filed as a special motion and treated as an ordinary law and motion proceeding and subject to regular motion fees. The reimbursement determination motion shall be treated as a special proceeding of a civil nature pursuant to Part 3 (commencing with Section 1063) of the Code of Civil Procedure. When no action is pending, the person making the motion shall be required to pay a first appearance fee. When an action is pending, the person making the motion shall pay a regular law and motion fee. Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(c) The court shall issue its findings, decision, or order, which shall be considered the final determination of the parties' rights and obligations with respect to the director's lien, unless the settlement is contingent on an acceptable allocation of the settlement proceeds, in which case, the court's findings, decision, or order shall be considered a tentative determination. If the beneficiary does not serve notice of a rejection of the tentative determination, which shall be based solely upon a rejection of the contingent settlement, within 30 days of the notice of entry of the court's tentative determination, subject to further consideration by the court pursuant to subdivision (d), the tentative determination shall become final.

Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(d) If the beneficiary does not accept the tentative determination, which shall be based solely upon a rejection of the contingent settlement, any party may subsequently seek further consideration of the court's findings upon

application to modify the prior findings, decision, or order based on new or different facts or circumstances. The application shall include an affidavit showing what application was made before, when, and to what judge, what order or decision was made, and what new or different facts or circumstances, including a different settlement, are claimed to exist. Upon further consideration, the court may modify the allocation in the interest of fairness and for good cause.

*(Amended by Stats. 2007, Ch. 188, Sec. 71. Effective August 24, 2007.)*

#### **14124.77.**

When the director has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the Medi-Cal Program, the director shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the director shall be entitled to a writ of execution against such beneficiary to the extent of the director's lien, with interest and other accruing costs as in the case of other executions.

*(Added by Stats. 1976, Ch. 621.)*

#### **14124.78.**

Notwithstanding any other provision of law, in no event shall the director recover more than the beneficiary recovers after deducting, from the settlement judgment, or award, attorney's fees and litigation costs paid for by the beneficiary. If the director's recovery is determined under this section, the reductions in subdivision (d) of Section 14124.72 shall not apply.

*(Amended by Stats. 2007, Ch. 188, Sec. 72. Effective August 24, 2007.)*

#### **14124.785.**

The director's recovery is limited to the amount derived from applying Section 14124.72, 14124.76, or 14124.78, whichever is less.

*(Added by Stats. 2007, Ch. 188, Sec. 73. Effective August 24, 2007.)*

#### **14124.79.**

In the event that the beneficiary, his guardian, conservator, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this code shall be given to the director in Sacramento except in cases where the director specifies that notice shall be given to the Attorney General. All such notices shall be given by insurance carriers, as described in Section 14124.70, having liability for the beneficiary's claim, and by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, conservator, personal representative, estate or survivors, if no attorney is retained.

*(Amended by Stats. 2003, Ch. 230, Sec. 69. Effective August 11, 2003.)*

#### **14124.791.**

(a) Subject to the director's prior right of recovery, a provider who has rendered services to a beneficiary because of an injury for which a third party is liable and who has received payment under the Medi-Cal program shall be entitled to file a lien for all fees for services provided to the beneficiary against any judgment, award, or settlement obtained by the beneficiary or the director against that third party. A provider may only recover upon the lien if the provider has made a full reimbursement of any fees paid by the department for those services.

(b) If either the beneficiary or the director brings an action or claim against the third party, the party bringing the action shall, within 30 days of bringing the action, give written notice to any provider who is eligible to file a lien under subdivision (a) of the action and of the name of the court or state or local agency in which the action or claim is brought. Notice shall be given by personal service or registered mail, and proof of service shall be filed in the action or claim.

(c) The provider's claim for reimbursement for fees for services rendered to the beneficiary shall be limited to the amount of the fees less 25 percent, which represents the provider's reasonable share of attorneys' fees for prosecution of the action and of the cost of litigation expense.

(d) No claim authorized by this section shall be permitted to the extent that the claim would reduce the director's right to recover pursuant to Section 14124.78.

*(Amended by Stats. 1992, Ch. 722, Sec. 108.7. Effective September 15, 1992.)*

#### **14124.792.**

If any provision of this article, or the application of any provision of this article to any person, firm, corporation, or other entity or to any circumstance or situation, shall be held invalid, the remaining provisions of this article shall not be affected thereby, and shall be given effect.

*(Added by Stats. 2007, Ch. 188, Sec. 74. Effective August 24, 2007.)*

#### **14124.795.**

It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has other available health coverage or insurance, the Medi-Cal program shall be the payer of last resort. Notwithstanding any other provision of law, any carrier described in Section 14124.70, including automobile, casualty, property, and malpractice insurers, shall enter into an agreement with the department to permit and assist the matching of the department's Medi-Cal eligibility file against the carrier's claim files, utilizing, if necessary, social security numbers as common identifiers for the purpose of determining whether Medi-Cal benefits were provided to a beneficiary because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance. The carrier shall maintain a centralized file of claimants' names, mailing addresses, and social security numbers or dates of birth. This information shall be made available to the department upon the department's reasonable request. The agreement described in this section shall include financial arrangements for reimbursing carriers for necessary costs incurred in furnishing requested information.

*(Added by Stats. 2003, Ch. 230, Sec. 70. Effective August 11, 2003.)*

#### **14124.80.**

The Legislature finds and declares that:

(a) Many instances of potential third-party liability, particularly workers' compensation claims, are not discovered by the department. Similarly, the Legislature finds that there are private nongovernmental sources of potential claim information which is unique to these private sources and not otherwise readily available to the department. This private information is unique in that, although the information may be shared between private claimants, including potential private lienors, the department is not privy to it and includes past adjudicated claims, expired or expiring health policy claims, long-term care and settlement situations where Medi-Cal is not identified in any application or filing for benefits. Additionally, there are applications and other filings made without any identification of potential Medi-Cal rights which become known to private sources because of this information sharing system. Further, there are other miscellaneous claims that have not been and will not be discovered in the ordinary course of administration by the department.

(b) There is a backlog of potential claims or liens which could result in the recovery of substantial amounts if private sources of information were available to the state.

(c) A cost-effective manner of recovering these potentially large amounts is through the contracting by the state, on a pilot program basis, with a private organization which possesses the expertise and resources required to rapidly discover and recover the lienable amounts owing by third parties for health care services provided by the Medi-Cal program, and which will receive compensation on a contingency fee arrangement, thereby supplementing the ongoing functions of the state in recovering lienable amounts, reducing the cost to the state of the recovery effort, and maximizing the amounts recovered for the Medi-Cal program.

(d) Attorneys or the beneficiary, his guardian, personal representative, estate or survivors of any of them who are currently mandated under Section 14124.79 to report Medi-Cal involvement are excluded from any further remuneration benefits under this section.

*(Amended by Stats. 1981, Ch. 1163, Sec. 12. Effective October 2, 1981.)*

#### **14124.81.**

The State Department of Health Services shall administer the provisions of Sections 14124.82 to 14124.88, inclusive. The department shall establish a pilot project for the discovery and recovery of amounts owing by third parties for health care services provided by the Medi-Cal program.

*(Added by Stats. 1981, Ch. 102, Sec. 119. Effective June 28, 1981.)*

#### **14124.82.**

(a) The department shall enter, by October 1, 1981, into at least two at-risk performance type contracts with private organizations that have access to information on cases with potential for the recovery of amounts owing for services rendered under the Medi-Cal program, and that have access to a substantial backlog period of information on past due Medi-Cal claims, as well as current and future potential claims. At least one contract shall cover



northern California claims, and at least one contract shall cover southern California claims. Any contractor, otherwise qualified under this section, may separately contract in each geographical area.

(b) Priority, by the terms of the contract or contracts, shall be given to the identification and recovery of claims nearing the statute of limitations, prior adjudicated claims, and prior existing injury claims. However, all claims which are older, in whole or part, than 12 months, at the time of discovery and notification by the contractor to the department, shall be subject to contractual lien recovery unless departmental personnel have previously identified these claims and have filed appropriate liens, notices, or other payment demands. A claim arises and the 12-month period begins when the department or its fiscal agent has first made payment for medical services related to the personal or workers' compensation action on behalf of a given recipient. The department may waive any time requirement, if it concludes that it will not otherwise discover the claim and be able to effect recovery. *(Amended by Stats. 1981, Ch. 1163, Sec. 13. Effective October 2, 1981.)*

#### **14124.83.**

The agreement shall include, but is not limited to, the following provisions:

(a) The contractor shall discover and recover amounts owing by third parties which may be subject to a claim for reimbursement.

(b) Payment to the contractor shall be based upon a no cost percentage of recovery formula, which shall not exceed 25 percent of the gross recovery upon the claim. It is the intent of the Legislature that "no cost" include all considerations for court costs, legal fees, and the universe of the case processing activity, not including, however, departmental processing.

(c) The contractor shall report periodically to the department concerning its progress in the discovery of cases and the recovery of amounts subject to claim, and shall provide such other information as the department may require to adequately monitor the progress of the contractor. Reports and other information shall be required only at one-month intervals.

*(Amended by Stats. 1981, Ch. 1163, Sec. 14. Effective October 2, 1981.)*

#### **14124.84.**

The department shall provide the contractor with such information as is reasonably necessary for the contractor to perform its obligations under the contract, including accounting data and other information the contractor may request.

*(Added by Stats. 1981, Ch. 102, Sec. 122. Effective June 28, 1981.)*

#### **14124.85.**

The contractor, for the duration of the contract period, shall have the powers of the Director of the State Department of Health Services as set forth in this article, except for the power to waive a claim under paragraph (2) of subdivision (b) of Section 14124.71. The contract shall specify the particular means and documentation of the delegation of powers under paragraph (1) of subdivision (b) of Section 14124.71. The contractor shall be subject to the provisions of Section 14100.2 except that those provisions shall not inhibit performance of the contract.

*(Added by Stats. 1981, Ch. 102, Sec. 123. Effective June 28, 1981.)*

#### **14124.86.**

The pilot project contract entered into by the department pursuant to Section 14124.82 shall not exceed a term of three years from the date of its execution. The contractor shall retain its rights and duties under the contract with respect to any claims or liens processed in whole or in part prior to the termination date of the agreement.

*(Added by Stats. 1981, Ch. 102, Sec. 124. Effective June 28, 1981.)*

#### **14124.88.**

(a) Subsequent to the expiration of the pilot project contract, the department, in its reasonable discretion, may execute a separate, additional agreement for the discovery and recovery of amounts which may be subject to claim pursuant to this article, subject to Sections 14124.81 to 14124.87, inclusive.

(b) The department, if it receives a competitive qualified offer of such services within the criteria set forth in Sections 14124.80 through 14124.87, shall separately contract for discovery and recovery of workers' compensation claims with one contract to cover areas of northern California and one to cover areas of southern California.

(c) (1) Priority and inclusion of claims shall be as set forth in subdivision (b) of Section 14124.82 and additionally shall include any matter on file with the Workers' Compensation Appeals Board for a period of more than 12 months unless the department has previously identified these claims and has filed the appropriate lien or liens.

(2) The contract may include, or may be subsequently amended to include, any or all previously identified claims and any other potential lien claims, identified or not, if the department determines that it will not otherwise be able to effectively process recovery. This paragraph shall cease to be operative on January 1, 1995.

(d) There shall be no cost to the contractor for claim detail reports provided by the fiscal intermediary. In all cases of workers' compensation appeals, payment shall be made directly to the state and a contractor shall not handle or have access to any moneys owing the state. In these cases a bond required by the state for collection agencies shall be sufficient. Contractor's files shall be subject to audit, pursuant to the contract, but shall remain the property of the contractor. At the request of the department, the contractor shall provide copies of any claims related to a particular recovery.

(e) The contract shall provide that the contractor, with the permission of the Attorney General, may appeal decisions of the Workers' Compensation Appeals Board.

*(Amended by Stats. 1991, Ch. 560, Sec. 4.)*

#### **14124.89.**

(a) Every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall, upon request of the department

for any records, or any information contained in records pertaining to an individual or group health insurance policy or plan issued by such insurer or plan against, or pertaining to the medical or dental benefits paid by or claims made against such insurer or plans under a policy or plan, make the requested records or information available upon a certification by the department that the individual is an applicant for or recipient of services under this chapter or is a person who is legally responsible for such an applicant or recipient.

(b) The department shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records, which procedure shall include such financial arrangements as may be necessary to reimburse insurers or plans for necessary costs incurred in furnishing requested information, and the time and manner such procedures are to become effective. Reimbursement to insurers or plans complying with the provisions of this section shall be at the same rate of reimbursement used to reimburse the Department of Motor Vehicles for providing information to insurance carriers.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether health benefits have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to items of medical care and services received by a particular individual for which Medi-Cal coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality of an applicant or recipient.

(e) The department shall implement the provisions of this section by January 1, 1983.

*(Amended by Stats. 2007, Ch. 188, Sec. 75. Effective August 24, 2007.)*

#### **14124.90.**

It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has third-party health coverage or insurance, the State Department of Health Services shall be the payer of last resort. In order to assess overlapping or duplicate health coverage, every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall maintain a centralized file of the subscribers', policyholders', or enrollees' names, mailing addresses, and social security numbers or date of birth, and where available, for all other covered persons, the names and social security numbers or date of birth.

This information shall be made available to the State Department of Health Services upon reasonable request. Notwithstanding Section 20134 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify Medi-Cal beneficiaries with third-party health coverage or insurance. A recipient's Medi-Cal identification card shall, where information is available, contain information advising providers of health care services of any third-party health coverage for the recipient. Providers shall seek reimbursement from available third-party health coverage before billing the Medi-Cal program. *(Amended by Stats. 2007, Ch. 188, Sec. 76. Effective August 24, 2007.)*

#### **14124.91.**

The State Department of Health Services shall, whenever it is cost-effective, pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services shall, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status, lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to an individual plan, whenever it is cost-effective. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

*(Amended by Stats. 1992, Ch. 722, Sec. 109. Effective September 15, 1992. Note: Amendment by Stats. 2003, Ch. 673, did not take effect; Ch. 673 was rejected as referendum Proposition 72 at the November 2, 2004, election.)*

#### **14124.92.**

(a) The department may pay administrative expenses and make incentive payments to any county, state, or federal agency, or a contracting agent of the department for identifying and reporting third-party health care coverage held or offered to beneficiaries under this chapter.

(b) Unless the third-party health care coverage identified is excluded under subdivision (d) from the incentive payment plan, an agency or contractor may be entitled to an incentive payment if the agency or contractor does all of the following:

(1) Identifies a case of which the department was not previously aware.

(2) Provides to the department adequate and necessary information relevant to the third-party health care coverage in order to make a claim for benefits or reimbursement for services rendered that would otherwise be paid by Medi-Cal.

(3) Reports to the department the identified third-party health care coverage within 30 days of the date of discovery on a form approved by the department.

(c) In no event shall any one incentive for each case identified exceed one month of savings received by the department for benefits paid by the third-party health care coverage.

(d) Third-party health care coverage that does not qualify for the incentive payment plan under this section shall be identified by the department based on policy limitations and cost-effectiveness. The types of coverage that do

not qualify under this section include those that to which any of the following apply:

- (1) Not specifically intended to provide third-party health care coverage, such as coverage that provides life or car insurance benefits, periodic benefits for disability or hospitalization, or income protection.
- (2) Coverage is limited to a specific diagnosis, unless the beneficiary has been diagnosed with a condition or disease specified in the coverage.
- (3) Coverage is limited to a specific circumstance, such as accidental injury or dismemberment.
- (4) Coverage is limited to one specific category of service.
- (e) For the purposes of this section, "third-party health care coverage" means health care service plans, benefits, insurance policies, and funds, including those described in Section 14124.90.

*(Added by Stats. 1992, Ch. 722, Sec. 110. Effective September 15, 1992. Note: The Section 14124.92 added by Stats. 1992, Ch. 718, was renumbered as 14124.93 by Stats. 1994, Ch. 146.)*

#### **14124.93.**

(a) The Department of Child Support Services shall provide payments to the local child support agency of fifty dollars (\$50) per case for obtaining third-party health coverage or insurance of beneficiaries, to the extent that funds are appropriated in the annual Budget Act.

(b) A county shall be eligible for a payment if the county obtains third-party health coverage or insurance for applicants or recipients of Title IV-D services not previously covered, or for whom coverage has lapsed, and the county provides all required information on a form approved by both the Department of Child Support Services and the State Department of Health Care Services.

(c) Payments to the local child support agency under this section shall be suspended for the 2003–04, 2004–05, 2005–06, 2006–07, 2007–08, 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2013–14, and 2014–15 fiscal years.

*(Amended by Stats. 2012, Ch. 47, Sec. 37. Effective June 27, 2012.)*

#### **14124.94.**

(a) When the rights of a Medi-Cal beneficiary to health care benefits from an insurer have been assigned to the department, an insurer shall not impose any requirement on the department that is different from any requirement applicable to an agent or any assignee of the covered beneficiary.

(b) The department, in the administration of the Medi-Cal program, may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under the Medi-Cal program.

(2) The person has received payment from a third party for the costs of the health services for the child, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child, or the provider of the health services, to the extent necessary to reimburse the department for expenditures for those costs under the Medi-Cal program. All claims for current or past due child support

shall take priority over claims made by the department for the costs of Medi-Cal services.

(c) For purposes of this section, "insurer" includes every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

*(Amended by Stats. 2007, Ch. 188, Sec. 77. Effective August 24, 2007.)*

WICWelfare and Institutions Code - WIC

## **MEDI-CAL LIEN CLAIMS IN PERSONAL INJURY ACTIONS**

An attorney seeking to recover against a liable third party for a client who has received health care benefits under the California Medical Assistance Act (Medi-Cal) must consider the rights of the State to be reimbursed. Under current law, the State has a right to assert a lien or claim against any recovery obtained by a Medi-Cal recipient against a liable third party or any and all settlements received for an injury.

Sections 14124.70 through 14124.791 of the Welfare and Institutions Code (W&IC) detail the State's right to assert a claims, intervene, file a lien, or file an independent action where Medi-Cal benefits have been extended to a recipient as a result of an injury or illness for which some third party is liable. Since the most common method used by the State to recoup Medi-Cal benefits is the filing of a lien or claim, this review is limited to a discussion of the of the rights and responsibilities of attorneys, their clients, and the State where Medi-Cal benefits is the filing of a lien or claim, this review is limited to a discussion of the rights and responsibilities of attorneys, their clients, and the State where Medi-Cal claims are involved.

The State's right to seek reimbursement under a lien claim exists in many kinds of action. A lien claim may be made, for example, in a malpractice action, against an uninsured motorist recovery (W&IC Sections 14124.70(a) and 14124.72(c)). It is not necessary that the amount of the State's lien claim be asserted or recovered as an item of special damages in order for recovery to be made under it; if a lien claim is properly asserted, it attaches to the entire judgment, award, or settlement regardless of the allocation of damages (W&IC Sections 14124.74(a) and 14124.78).

Generally, notice of the statutory Medi-Cal lien is given by the filing of a Notice of Lien in the action. However, W&IC Sections 14124.70-14124.791 make it clear that the lien arises by operation of law, and that the State also has a right to assert a claim for Medi-Cal benefits provided, whether or not a complaint or formal action has been filed. Thus the term "Lien claim" used throughout this article includes both formal liens and those claims for reimbursement made in cases where no formal action has been actually initiated.

### **NOTICES**

When a complaint or Worker's Compensation claim is filed against an allegedly liable third party, notice must be given to the Director of the Department of Health Services within 30 days of the filing of the action (W&IC Section 14124.73). Also, before a judgment, award, or settlement in any action or claim may be satisfied, notices must be given which would give the Director a "reasonable opportunity to perfect and satisfy his lien" (W&IC Sections 14124.76 and 14124.79). Since, as mentioned earlier, the Medi-Cal lien claim attaches whether or not suit has been filed, notices must be given whenever a suit or claim has been filed, whenever final settlement of a suit or claim is contemplated, or whenever there is final settlement of a claim without suit or administrative adjudication. A settlement negotiated without notice to the Director could be set aside as being violative of W&IC Section 14124.76.

Responsibility for giving the notices rests both with recipient and his/her attorney or personal representative (W&IC Section 14124.79). Should the State's right to seek reimbursement be frustrated by failure to give the specified notices, the recipient and his/her attorney could be held jointly liable for the breach of the duty to give notice.

Attorneys should determine if their clients have had any part of their medical expenses paid by the Medi-Cal Program. All notices for personal injury cases, including medical malpractice, uninsured motorist, emotional distress, wrongful death, etc., should be sent to the Department of Health Services. All Worker's Compensation notices should be sent to Boehm & Associates. Notices should be sent to:

#### Personal Injury Cases

Department of Health Services  
Recovery Section/Personal Injury Unit  
P.O. Box 2471  
Sacramento, CA 95812-2471  
(916)323-4836

#### WCAB Cases

Boehm & Associates  
ATTN: Rhondee Jacopetti  
1321 Harbor Bay Parkway, Ste. 250  
Alameda, CA 94501  
(510)865-0544

All notices should contain the following information:

- 1 Medi-Cal recipient's name. If a minor, the parents' or guardians' names should also be given.
- 2 The Medi-Cal Identification Number(s) (example: 19-20-2001346-011). They may be obtained from the Medi-Cal card or perhaps from medical bills which have been paid by Medi-Cal. All numbers must be reported; a recipient may have had more than one number if the county of residence or the aid category changed.
- 3 Social Security Account (SSA) Number.
- 4 Date of birth.
- 5 Date of injury.
- 6 Name and address of treating providers of health care and dates of service.
- 7 If a complaint has been filed, the case name, court in which it was filed, docket number, defendant's name and address, and defendant's attorney's name and address should be provided. Much of this information can be provided by forwarding a copy of the complaint.
- 8 The identifying data, such as group name and policy number, for any private health coverage the person may have. This could reduce the gross amount of the Medi-Cal claim.
- 9 The identifying data for any automobile or homeowners insurance applicable.

Early notification is important because a number of record centers may have to be contacted to compile the information on payments made by Medi-Cal and extract the injury-related services.

#### **SHARE OF ATTORNEY'S FEES AND COSTS (25 PERCENT RULE)**

When some form of action is taken by a recipient through an attorney and the State seeks reimbursement, the state must reduce its gross lien claim by 25 percent, which represents the Director's reasonable share of attorney's fees paid by the beneficiary. It must be further reduced by a pro rata share of any litigation costs which must be borne by the recipient (W&IC Section 14124.72(d)). These deductions are in the nature of a contribution for the fees and costs incurred by the recipient and not additional payments to the attorney. The statutes contemplate that attorneys will obtain the full amount of their fees and litigation costs from the gross settlement or judgment. The lien reductions, in recognition of these charges against the gross recovery, inure solely to the benefit of the recipient.

The State will accept 75 percent of any lien claim asserted in TORT actions in full satisfaction of it without further verification of the fee actually charged. However, before a pro rata share of the litigation costs will be deducted, the attorney must submit an accounting of these charges. This pro rata share of cost is computed by multiplying the ratio of the gross lien claim to the gross judgment or settlement, times the litigation costs.

The right to reduce the lien claim by 25 percent in recognition of attorney's fees and a pro rata share of litigation costs exists only when the recipient personally incurs a responsibility to pay the (W&IC Section 14124.72(d)). Thus, in administrative worker's compensation actions where attorney's fees and costs are awarded directly to the claimant's attorney, no reduction in the lien claim is allowed. Also, a reduction does not apply to a Medical Payments (Med-Pay) portion of a settlement since Med-Pay is to be used for repaying medical bills.

#### **50 PERCENT RULE**

The Medi-Cal claim for reimbursement may never exceed one-half of the net recovery to the recipient. The "net recovery" is that which remains after deducting the attorney's fees, itemized litigation costs, and itemized medical expenses relating to the injuries paid for by the recipient (W&IC Section 14124.78). For example, Medi-Cal has paid \$30,000.00 for injury-related services, but there is only a \$15,000.00 gross settlement negotiated. If a contingent fee of one-third (\$5,000.00) is charged and costs were \$1,000.00, it would leave a net settlement of \$9,000.00. Medi-Cal would be limited to one-half of the net settlement or \$4,500.00 (Note: This \$4,500.00 for Medi-Cal is not subject to any further reduction for "attorney fees").



If a portion of the medical expenses is paid by private insurance of a publicly funded health benefit program, those payments may not be used to reduce the gross settlement or judgement. Only those services for which the person is legally liable and which the person actually pays prior to settlement may be deducted. (Note: If Medi-Cal has paid for any portion of these services, no deduction is allowed.)

#### **COMPROMISES**

In addition to the statutorily mandated reductions, further compromise of the State's Medi-Cal claim may be made on a case-by-case basis. If payment of the maximum allowable lien claim would result in undue hardship on the recipient, the lien claim may be further reduced at the discretion of the Director (W&IC Section 14124.71(b)). Such a reduction would have to be justified by the submission of medical reports and any other pertinent documentation which would tend to establish undue hardship.

Authority to make reductions below those prescribed in W&IC Sections 14124.72(d) and 14124.78 is vested solely with the Director of the Department of Health Services and his/her delegates. The court or administrative tribunal having jurisdiction over the action does not have authority to order lien reductions without the Director's consent. All inquiries and requests for compromises on lien claims or general information should be addressed to:

*Department of Health Services  
Recovery Section/Personal Injury Unit  
P.O. Box 2471  
Sacramento, CA 95812-2471*

#### **PROVIDER LIENS**

Often an attorney will receive a lien from a provider separate from the Medi-Cal lien. W&IC Section 14124.74(a) allows Medi-Cal first lien rights. Passage of Senate Bill (SB) 1719 on September 14, 1992 allows Medi-Cal providers to file liens for services paid by the Medi-Cal program. A provider lien under SB1719 is only collectable after the Medi-Cal program has been fully reimbursed by the provider for those services (W&IC Section 14124.791(a)). Please refer to W&IC Sections 14019.3, 14019.4, 14124.791 for more details. Medi-Cal Managed Care Programs and their sub-contractors are prohibited from filing provider liens (California Code of Regulations Section 53222(b)). If an attorney has questions about duplicate liens by Medi-Cal and a provider they should contact the Personal Injury Unit for clarification. No claim authorized by SB1719 shall be permitted to the extent that the claim would reduce the Director's right to recover under the 50 Percent Rule (W&IC Section 14124.791(d)).