TRANSPORTATION matters
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# DOT/FMCSA - Noteworthy Updates

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On 3/13/20, the Federal Motor Carrier Safety Administration (FMCSA) issued an unprecedented national emergency declaration to provide hours of service (HOS) relief to drivers transporting goods needed to respond to the Coronavirus Pandemic. Those commercial motor vehicle (CMV) operations exempted include those meeting needs for:

- Medical supplies and equipment related to testing, diagnosis and treatment of COVID-19;
- Supplies and equipment, including masks, gloves, hand sanitizer, soap and disinfectants, necessary for healthcare worker, patient and community safety, sanitation, and prevention of COVID-19 spread in communities;
- Food for emergency restocking of stores;
- Equipment, supplies and persons necessary for establishment and management of temporary housing and quarantine facilities related to COVID-19;
- Persons designated by federal, state or local authorities for transport for medical, isolation or quarantine purposes;
- Personnel to provide medical or other emergency services.

The exemption extends to the driver returning to the carrier's terminal or the driver's normal work reporting location. However, once those staging areas are reached, the HOS-exempt driver must have 10 hours off duty if transporting cargo and 8 hours off duty if transporting passengers. A copy of the Emergency Declaration may be found here: https://bit.ly/2Wp8ICn

On 3/2/2020, the FMCSA sent a final rule on HOS changes to the White House. As we previously reported to you, the notice of proposed rulemaking sought the following changes to HOS regulations:

- Extend on-duty time by 2-hours for adverse weather;
- Extend the "short haul" exception from 100 air-mile radius to 150 miles and increase allowable drive time from 12 hours on-duty to 14 hours;
- Allow drivers to split the required off-duty time into two periods: one period of at least 7 consecutive hours in the sleeper birth and a second period of not less than 2 consecutive hours either off-duty or in the sleeper berth;
- Allow one off-duty break of between 30 minutes and 3 hours that would pause the 14-hour driving window as long as the driver takes 10 consecutive hours off-duty at the end of the shift.

Since the electronic logging device (ELD) mandate took full effect in December 2019, the FMCSA has seen Hours of Service (HOS) violations decrease by 50%. However, the FMCSA has seen a significant increase in log falsification after an initial decline in the violation. The FMCSA suggested the dramatic increase in falsifications is a result of inspectors becoming more proficient with the ELD systems rather than a greater share of drivers falsifying the logs. The FMCSA expects to see falsifications decline over time.

On 2/14/2020, the public comment period closed regarding the National Association of the Deaf's (NAD) petition to end certain medical examination requirements for commercial driver's license (CDL) applicants. Specifically, the NAD's petition seeks an end to the requirement that CDL holders pass a hearing test and be able to speak without a translator as violations of the Rehabilitation Act of 1973. Currently, a driver must "perceive a forced whisper voice in the better ear at not less than 5 feet with or without the use of a hearing aid." Drivers who fail the hearing test may seek an exemption. The FMCSA has granted 450, five-year exemptions since it began doing so in 2012. In 2017, the FMCSA studied the safety ratings of 217 exempted drivers and concluded that these drivers had a lower crash rate than the national average and lower violation rate and fewer out of service violations than the study's control group.

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# Medicare Liens: Another Concern Prior to Settlement?

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In our last newsletter we discussed the issues posed by ERISA liens and how the presence of an ERISA lien can complicate a potential settlement. Another similar issue that complicates settlements is the potential presence of a Medicare lien. This applies to workers' compensation and liability cases.

The Medicare Secondary Payer Act (MSPA), 42 U.S.C. 13957(b)(2), prohibits Medicare from making medical payments on behalf of a Medicare beneficiary if a primary plan (liability, workers' compensation, or no-fault insurance policy) has the responsibility to pay for such treatment. The MSPA specifically requires primary plans to reimburse the appropriate trust fund for any payment made by Medicare if it is demonstrated that the primary plan has or had a responsibility to make the payment. Payments made by Medicare which are the responsibility of a primary plan are conditioned on reimbursement, and are referred to as "conditional payments." A primary plan's responsibility to reimburse Medicare for these payments may be demonstrated by a judgment in favor of a beneficiary, a settlement with a beneficiary, a contractual obligation to pay a beneficiary, or by other means.

In order to access whether you are dealing with a potential Medicare lien, you first need to determine if a claimant is a Medicare beneficiary. This can usually be determined by evaluating a claimant's age. Most individuals are entitled to Medicare coverage when they reach sixty-five (65) years of age. However, a claimant can become a Medicare beneficiary prior to reaching sixty-five (65) years of age in certain circumstances. Usually, this will occur when a claimant has applied for, and is awarded, Social Security Disability benefits. A claimant can also be entitled to Medicare coverage if he/she had End Stage Renal Disease (ESRD). As such, prior to settling a claim, you always want to determine if the claimant is a Medicare beneficiary, and in fact, federal law requires you to make that determination.

If you determine a claimant is a Medicare beneficiary based on age, entitlement to Social Security Disability, or ESRD, then you need to access whether Medicare is asserting a lien pursuant to the MSPA. Usually, if a workers' compensation claim has been accepted as compensable and all medical payments have been made through workers' compensation, there should be no lien. However, you will still need to confirm this with Medicare prior to any settlement through a request for lien information to the Centers for Medicare and Medicaid Services' (CMS) relevant contractor. The CMS contractor that handles lien recovery in accepted workers' compensation claims is the Commercial Repayment Center (CRC).

If the claimant is a Medicare beneficiary and has a workers' compensation claim that has been denied, or a liability claim, then it is more likely that Medicare paid for some medical treatment and a lien will be asserted. Again, you will need to confirm whether a lien is being asserted and the amount of lien through a request for lien information to CMS' relevant contractor. The CMS contractor that handles lien recovery in denied workers' compensation and liability claims is the Benefits Coordination and Recovery Center (BCRC).

If a lien is being asserted, CMS will send a Notice detailing the amount of the lien and the specific medical treatment paid for by Medicare. This Notice should be reviewed carefully, as CMS will oftentimes include medical treatment paid for by Medicare that is not related to the injuries being alleged in the workers' compensation claim. If you feel that CMS is including treatment in the lien that was not related to the workers' compensation claim, then you can submit a dispute letter to CMS challenging the validity of the charges. This is easier for a Defendant to do in a workers' compensation claim. In a liability claim, the claimant should be the one disputing the lien.

The issue of payment of a potential Medicare lien should be resolved as part of settlement discussions. It should be made clear which party will be responsible for paying the Medicare lien. Once payment of the lien is made to CMS, a closure letter will be issued advising the parties that the lien issue has been resolved.

It should also be noted that a lien letter from CMS will only cover any medical payments issued by Medicare Parts A and B. If claimant has a Medicare Plan under Parts C or D, then you will need to specifically request lien information from the administrator of that Part C or D Plan. So, in addition to determining if a claimant is a Medicare beneficiary, you will need to determine if the claimant is covered by a Medicare Part C or D plan.

If you have any questions or concerns about Medicare liens, we encourage you to reach out to our Medicare Compliance Group. The group is led by Shannon Metcalf, who is a certified Medicare consultant.

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# Sykes v. Vixamar and Progressive Univ. Ins. Co.: A Discovery Bar or Discovery Strategy?

Walsh

This article was reprinted with permission from the February 2020 edition of *The Resource,* the newsletter of the North Carolina Association of Defense Attorneys.

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"Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning." - Sir Winston Churchill, Remarks at The Lord Mayor's Luncheon, Mansion House, London (Nov. 10, 1942).

From the time it took effect, North Carolina Rule of Evidence 414 profoundly changed how tort claims are investigated, negotiated, and litigated. However, but for withstanding a constitutional challenge before a three-judge panel in Pollard v. Huber, the Rule has faced little scrutiny in the courts. Last summer, after initial successes in defense of Rule 414, the Court of Appeals opinion in Sykes v. Vixamar and Progressive Univ. Ins. Co. caused us to take pause and consider what Rule 414's language regarding "amounts actually necessary" to satisfy a medical expense actually means.

**Rule 414**

We know that Rule 414 limits the admissibility of medical expenses to "the amounts actually paid to satisfy the bills that have been satisfied, regardless of the source of payment, and evidence of the amounts actually necessary to satisfy the bills that have been incurred but not yet satisfied." The primary dispute since 2011 has been what constitutes relevant evidence of those expenses. See Nicholson v. Thom, 236 N.C. App. 308, 337, 763 S.E.2d 772, 791 (2014) (noting in dicta that Rule 414 abrogated the collateral source rule with regard to past medical expenses). See also Sigmon v. State Farm Mut. Auto. Ins. Co., 5:17-CV-00225, 2019 WL 7940194 at *2 (WDNC Nov. 14, 2019) (holding that Rule 414 is limited to past medical expenses but that a plaintiff may admit the total amount of medical expenses for tangential arguments "such as pain and suffering, embarrassment, or reputational harm – related to the alleged 'bad debt' or 'uncollectible' write offs").

Amendments to General Statute Section 8-58.1(b) took effect on the same date as Rule 414. This section receives much less fanfare but does the heavy lifting by clarifying how a defendant may overcome the presumption that a plaintiff's medical expenses are reasonable. Section 8-58.1(b) states that when a "provider of hospital, medical, dental, pharmaceutical, or funeral services gives sworn testimony that the charge for that provider's service either was satisfied by payment of an amount less than the amount charged, or can be satisfied by payment of an amount less than the amount charged" then the presumption of a medical bill's reasonableness is rebutted. Therefore, to contest the admission of a plaintiff's medical expenses, a defendant may "introduce evidence that some of those bills were written off" or, in the case of the tangential arguments described in Sigmon, a defendant may receive "a limiting instruction informing the jury that the amount written off cannot be considered for determining medical expenses."

**Sykes v. Progressive**

Following enactment of Rule 414, attorneys and paralegals scrutinized write offs and contractual adjustments and began to consider why a provider might be required to take less than sticker price. Cue the Fair Health Care Facility Billing and Collections Practices Act.

NC General Statute Section 131E-91 was enacted in 1991 and, at first, only required hospitals to provide an itemized list of charges within 30 days of discharge if requested by the patient. In 2013, the statute was expanded to its current form and subsection (c) was added, which states: "A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer."

Based on Rule 414's favorable treatment in Nicholson, and the clear language of Rule 414, defendants naturally argued that, pursuant to Section 131E-91, if a plaintiff owed nothing on a medical bill, the amount "actually necessary to satisfy the bills that have been incurred but not yet satisfied" was in fact zero.

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**Sykes** *cont. from page 3*

In Sykes, the Court of Appeals took up the issue of whether Section 131E-91(c) required hospitals to bill a patient-plaintiff's medical insurance in order to maintain a lien against a plaintiff's recovery in a civil action. The Sykes Court held that Section 131E-91(c) was "not intended to force hospitals to bill health insurers" and, therefore, timely billing to a plaintiff's health insurer was not required to maintain a lien against a plaintiff's recovery.

The Court of Appeals acknowledged that the provider abandoned its right to seek payment from plaintiff by means other than the litigation when it failed to timely submit a claim to plaintiff's health insurer. Thus, if plaintiff lost on liability, so too did the provider. Progressive argued that this elimination of plaintiff's liability to the provider outside of litigation (due to untimely billing) eliminated the provider's lien on plaintiff's recovery. In effect, there could be no lien without an underlying debt.

On this point, Progressive cited cases in which medical providers sought to collect more through a statutory lien than they would be entitled to collect through health insurer contracts. In this regard, the Court of Appeals made two points. First, the provider's failure to timely bill health insurance did not wipe away the debt because an alternative payment source - defendant - remained available. Second, the cases cited by Progressive were distinguishable because, in those cases, the hospital was seeking more than the amounts paid and actually necessary to satisfy the bill. The hospitals in cases cited by Progressive were seeking reimbursement for the health insurance contractual adjustment, which the hospitals would not have been paid under any circumstance. On this second point, the Court of Appeals specifically stated in dicta that "defendants may introduce evidence showing a hospital seeks more through its lien than it would have otherwise accepted from a patient or health insurer. . . . . Evidence that the hospital would accept less than the amount claimed in a medical lien to satisfy the underlying bill is admissible to challenge the reasonableness of the bill. . . . Defendants in these cases may seek discovery on this issue and courts should freely admit this evidence at trial."

**Rule 414 after Sykes**

Rule 414 was not directly at issue in Sykes; however, the Court's holding that the medical provider's lien (rather than amount billable to plaintiff) was evidence of the amount "actually necessary to satisfy the bills that have been incurred but not yet satisfied" will affect how defendants negotiate and litigate tort claims going forward. After Sykes, Defendants can no longer argue that a total write off under Section 131E-91(c) results in exclusion of the original bill or lien. Whether the Court of Appeals' logic allows providers to claw back charitable write offs or uninsured discounts and assert liens on the original amounts is a question for another day.

The silver lining to Sykes is the clear affirmation given to defendants, albeit in dicta, that a defendant may develop evidence from a provider about what the provider would have been required to accept under a health insurance contract or, perhaps, under required charity care discounts, and that such evidence shall be "freely" admitted by the trial court.

Sykes was the first time since 2011 that we have had to pause and re-think the language of Rule 414. It marks the "end of the beginning" to our use and understanding of the Rule, opens up new issues for litigation, and begs questions of language that we believed to be plain and clear. Nevertheless, Sykes' affirmation that defendants are entitled to pull back the curtain of provider's billing practices gives defendants the strongest support yet for discovery and motion practice on Rule 414.

N.C. Gen. Stat. § 8C-1, Rule 414 (2019).

N.C. Gen. Stat. § 8-58.1(b) (2019).

Nicholson v. Thom, 236 N.C. App. 308, 337, 763 S.E.2d 772, 791 (2014)

Sigmon v. State Farm Mut. Auto. Ins. Co., 5:17-CV-00225, 2019 WL 7940194 at *2 (WDNC Nov. 14, 2019).

1991 N.C. Sess. Laws Ch. 310 (H.B. 588).

2013 N.C. Sess. Laws Ch. 382 (H.B. 834).

Sykes v. Vixamar and Progressive Univ. Ins. Co., 830 S.E.2d 669, 673, 830 S.E.2d 669.

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**DOT/FMCSA - Updates** *cont. from page 1*

On 2/28/2020, the FMCSA announced a study to assess the prevalence, seriousness, and nature of harassment against female and minority male commercial drivers. As justification for the study, the FMCSA cited a 2006 article by the Security Journal, which reported 42% of female commercial drivers experiencing one or more instances of workplace violence and a 2017 USA Today article documenting harassment of minority, male drivers. The FMCSA expects the anonymous survey to be given to 880 drivers, including 80 who had previously reported no incidents and 800 respondents who have reported one or more incident.

On 2/21/2020, the FMCSA announced that the Drug and Alcohol Clearinghouse has registered nearly 8,000 violations since going live on 1/6/20. The Clearinghouse currently has over 650,000 registrants and must be used by carriers to check CDL holders' violations in pre-employment drug screenings and at least once per year. State agencies may voluntarily query the Clearinghouse but will be required to do so beginning 1/6/2023.

On 2/18/2020, the Department of Transportation (DOT) issued a compliance notice warning drivers of mislabeled hemp-based cannabinoid (CBD) products that may contain illegal levels of tetrahydrocannabinol (THC), the intoxicating substance in marijuana, and result in a positive urine drug screen. Hemp products are legal when containing less than .3% THC; however, because the Food and Drug Administration (FDA) does not certify CBD products, there is no oversight to ensure labeling is accurate. Currently, urine drug screens do not test for CBD.

## Attorney Spotlight: Derrick Foard

*An attorney in the Charlotte office, Derrick's practice focuses in the area of workers' compensation. He is passionate about advocating for his clients and enjoys the relationships he is able to develop through his practice.*

***Q: What is your proudest moment?***
**DF:** Passing the bar exam and becoming the first attorney in my family.

***Q: What keeps you busy on the weekends?***
**DF:** Going to my daughter's cheerleading competitions up and down the east coast.

***Q: What's your most cherished family tradition? Why is it important?***
**DF:** Our annual Christmas day family gathering. As someone who really values family, I love spending time with my immediate and extended family. What better way is there to spend the holidays than with loved ones?

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