

## REV - Lien Recovery Procedure

**Purpose:** When injury or trauma occurs involving a Medicaid member, and third-party liability (TPL) is established, a Medical Assistance Lien is filed if Iowa Medicaid has paid claims related to the trauma. Because Medicaid is the “payer of last resort” the Revenue Collections Lien Recovery Unit investigates the trauma and recoups payments from any liable third party.

*“When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, upon all monetary claims which the member may have against third parties. A lien under this section is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member’s attorney when the member’s eligibility for medical assistance is established...” Iowa Code, Section 249A.6.*

### Identification of Roles:

#### IME Core Unit

- a) On a monthly basis, Iowa Medicaid Enterprise (IME) CORE unit creates Trauma Lead Letters based on paid claims. These letters are mailed to the Medicaid Recipient for review, completion and mailing to the IME.
- b) Receives mailed and faxed Lien Recovery lead documents and scans them into the OnBase system.
- c) Routes scanned documents into REV MISC and REV01 Lien Recovery Logging Queues.

#### IME Revenue Collections

- a) Transfers fax referrals from REV MISC to REV Lien Recovery LC Queue,
- b) Fields and gathers information from lien recovery lead phone calls, faxes, and mail.
- c) Prints documents from REV03-Lien Recovery Queue and starts hard copy folder.
- d) Opens case in Maestro.
- e) Orders Claims History.
- f) Researches Medicaid Management Information Systems (MMIS) for member’s Medicaid eligibility status and dates.
- g) Reviews claim histories for pre-existing conditions and claims related to the casualty incident.
- h) Relates claims in Maestro
- i) Files a lien with appropriate parties and continues follow up on the case.
- j) Posts payments

- k) Releases liens when payment is made, or no lien amount can be recovered.

### **Performance Standards:**

1. Provide monthly reports of lien recovery activity by the tenth business day of the month with state fiscal year – to – date data and updated for the previous month's activity.
2. Prepare and process credits or adjustments against recoveries received within 20 business days.

### **Path of Business Procedure:**

**Step 1:** Revenue Collections receives trauma leads from the following sources:

- a) Attorney or Insurance Company letters and faxes with requests for lien balance or medical claims information. These documents are received and scanned into OnBase.
- b) Phone calls from Attorneys or Insurance Companies requesting lien balance or medical claims information.
- c) Trauma Code Lead letters sent by Core to Medicaid members after a diagnosis code analysis of their medical claims indicates the injury possibly resulted from a trauma. These letters are received at the IME and scanned into OnBase.
- d) Phone calls or emails referred from the Medicaid Fraud Hotline.
- e) Iowa Medicaid has a fraud hotline that is handled in a call center in Council Bluffs. At times there may be a member that has received treatment in which the incident is later reported to the hotline. The member as well as providers can make a report. The Account Managers in Member and/or Provider Services may refer the case to the Revenue Collections Account Manager for a potential lien recovery case. Revenue Collections will handle these cases as they do trauma lead letters. If there is a potential case a new case file for the member is opened and worked. If there is no potential case then no case file is opened.

**Step 2:** Upon receipt of a lien recovery lead, Revenue Collections creates both a physical file housed at the IME and an electronic file in the Health Management Systems (HMS) proprietary case management system, Maestro, to manage the lien recovery case. Revenue Collections maintains a database of contacts involved in the case, and creates legal documentation within Maestro to submit to the involved legal parties and county courts.

- Step 3:** To determine the lien recovery amount, the Lien Recovery Caseworker (Caseworker) utilizes two (2) sources: the MMIS Recipient History Profile (Report IAMC9500-R001) ordered from Core and Maestro, which loads all claims that Medicaid has paid on behalf of the injured party electronically from MMIS into Maestro.
- Step 4:** The Caseworker first reviews the MMIS Recipient History Profile and associates claims to the lien amount that resulted from the injury sustained in the incident. Then the Caseworker matches and posts the related claims from the MMIS Report into the Maestro Claims Screen. Maestro automatically calculates the lien amount by totaling the cost of all the associated claims. The Caseworker files the lien, which lists the total amount of paid claims related to the incident with the County Clerk of Court where the member resides, and sends a Notice of Lien to the attorney representing the member, or to the insurance carrier with a copy to the Medicaid member if unrepresented by an attorney, or directly to the member if self-represented and there is no liable third party contact information is available. The Medical Assistance Lien is periodically updated and filed with the appropriate County Clerk of Court as required, and the attorney, carrier or member are notified of the updated lien amount.
- Step 5:** The lien amount undergoes a review by the various parties. If the amount is disputed, Caseworker and the State TPL Policy person will work with the interested parties to negotiate a settlement amount. Pursuit of payment must begin within sixty (60) days after liability has been established, which is at the time of settlement or judgment.
- Step 6:** The Caseworker pursues recovery of the lien amount by submitting a Final Statement of Payment to the attorney or liable third party. Once Revenue Collections receives a check for the full lien amount, a Release of Lien is filled with appropriate County Clerk of Court and the payment is posted in Maestro. The Caseworker accesses the Settlement History Screen in Maestro and posts payment to each individual claim covered by the lien recovery check. After all the claims are accounted for, the case is closed if the check is for the full lien amount. If not, Maestro will post as many claims as the payment will cover, starting with the oldest consecutive claims first. Additionally, a Revenue Collections Posting Specialist will create the Adjustment Request E-Form in OnBase to credit the claims in MMIS.

- Step 7:** In order to show the lien amount as paid in Maestro, the payment has to be posted at the claims level in Maestro. If the payment is a full payment all claims that were related and filed in the lien are updated to show paid.
- Step 8:** If the amount received from liable third party does not cover all related claims, Maestro will automatically apply payment to claims in consecutive order until amount of payment is exhausted.
- Step 9:** In the Payment Information Section of Maestro, these fields are populated:
- a) Deposit Date:
  - b) Receive Date:
  - c) Post Date:
  - d) Check Amount:
  - e) Paid Amount:
  - f) Check Date
  - g) Check Cash Control Number (CCN) -enter into invoice # field of Maestro.
  - h) Once the payment is applied a release of lien notice, or an updated notice of the remaining amount is sent to the contact.
- Step 10:** If an attorney or insurance carrier informs the Caseworker that related claims were paid directly to a provider, the Caseworker will request documentation of amount paid, dates of service and name of provider. Once documentation is received from the attorney or insurance carrier that a provider was paid directly for related claims, the Caseworker will research the claims in MMIS and verify whether or not the provider reimbursed Medicaid for the double payments. If the provider has not refunded the overpayment, a Provider Reimbursement Request letter is mailed to the provider. A payment is posted toward the lien amount, the lien is released and the file is closed. However, the remaining lien balance owed by the provider will remain outstanding in the HMS Case Management System until the provider refunds the balance due to the IME.
- Step 11:** If the Medicaid member is an Iowa Care recipient, instead of mailing out a Provider Reimbursement Request letter, the Caseworker will notify the IME Provider Services Unit with a copy of the notification sent to the IME Provider Cost Audit Unit and the State Revenue Collections Unit Manager. In this instance, the payment (if any) received from the attorney or insurance carrier would be posted as payment in full and there would be no outstanding lien balance.
- Step 12:** When a restitution check from a criminal case is received from a County Clerk of Court, and the Caseworker is able to identify the Medicaid member and IME Case, the check is deposited and the Revenue Collections Posting Specialist will create a History Adjustment Request E-Form in OnBase to show that a payment was received that was applicable to a Medicaid member's claim(s). The adjustment would be informational only and would not result in a refund to a provider or member. Informational adjustments are neither critical nor mandatory. If a

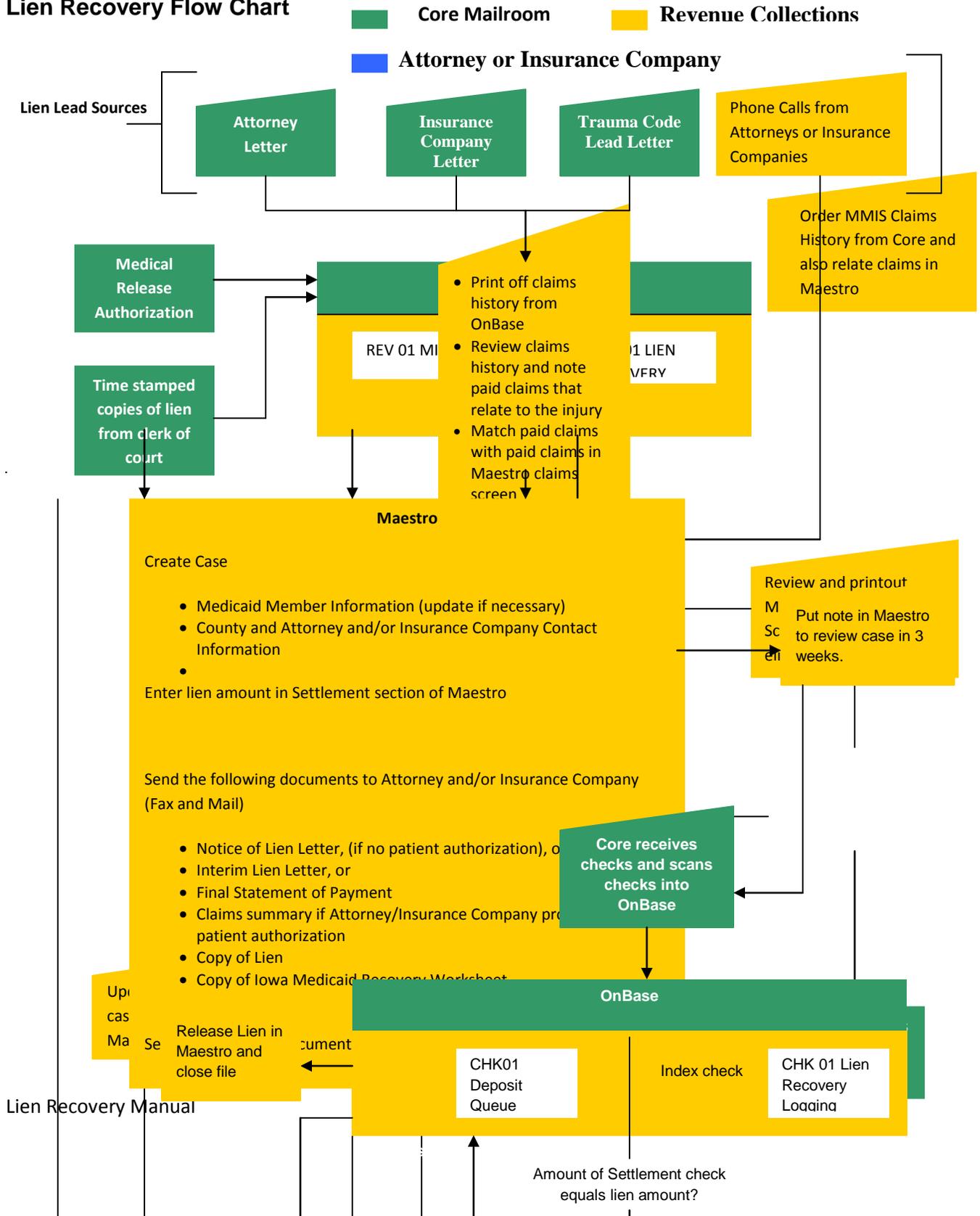
- restitution check is received by Revenue Collections without reference to the relevant Medicaid member or IME Case Number, the check is deposited and no Adjustment Request E-Form is created.
- Step 13:** If a provider receives a request from the Medicaid Recipient for medical records or bills: they should release the billing to medical records to the Medicaid Recipient, but notify Revenue Collections in writing or by telephone if there was an accident and provide any TPL data. If the request for billing statements or medical records is coming from an outside party, then the provider needs to fax Revenue Collections the written request and medical authorization form. Revenue Collections will then review and approve the release of claim billings or medical records via a telephone call to the provider. Revenue Collections can be contacted by telephone at (515) 256-4620 or (888) 543-6742.
- Step 14:** Each month by the 5<sup>th</sup> business day Revenue Collections will submit two reports to the Unit Manager. The reports will contain specific information and is populated systematically by HMS.
- a) The Iowa Lien Report
  - b) The Ahlborn Tracking Report
- Step 15:** When a file is opened, a Lien Recovery Case File Worksheet is completed. The file is comprised of lien and release of lien forms, lien transmittal letters to County Clerk; a copy of the MMIS member eligibility; the letter of representation and authorization; a copy of the notice of lien or lien transmittal letter to third party; all correspondence or phone messages pertaining to this file; the MMIS claim summary printout and the Maestro claim summary printout; and any Maestro notes. After it is closed, a copy of the check and any accompanying documentation; a copy of the Maestro payment screen and a copy of the Release of Lien are placed in file.
- Step 16:** The Caseworker reviews the claims submitted before the incident to gain a sense of any pre-existing health conditions. For any claims submitted after the incident, The Caseworker determines if they relate to the injury. The amount of all claims related to the accident are totaled and compared to the amount auto-calculated in Maestro as the lien recovery amount.
- a) Caseworker orders claims histories, generally two (2) months prior to date of injury through the MMIS System to load into OnBase. The Caseworker prints claims histories from OnBase that were ordered the day before into a hard copy format.
  - b) If the Lien Recovery Caseworker is not familiar with a diagnosis code or drug name, the following reference tools are available online:
    - 1) WebMD
    - 2) Medline Plus Medical On-line Dictionary
    - 3) Revenue Collections Lien Recovery proprietary lists noting frequently prescribed drugs and medical diagnoses

- Step 17:** If the diagnosis or drug relates to the injury sustained in the incident, the Caseworker circles the claim and relates the claim to the case in Maestro.
- Step 18:** After conducting an analysis of all the claims, Revenue Collections uses a tape calculator to add up all the claims related on the MMIS claims summary printout. Maestro automatically adds up the amount of all claims related to the case from the MMIS claims history printout and Revenue Collections compares this amount to the Medicaid Lien Recovery amount in Maestro to verify that all claim amounts were added correctly.
- Step 19:** Prepares and sends lien correspondence to County Clerk of Court **(unless case is a Civil class action suit)** and attorney or liable insurance company.
- Step 20:** If the case is a Civil Class Action Suit only the Attorney is sent the letter, No Clerk of Court Document is needed.
- a) Use the Microsoft Word Subrogation Letter
  - b) No lien is filed
  - c) A Medicaid Member claims history will be sent to the attorney or firm for settlement reconciliation once a valid authorization is received.
- Step 21:** Notification sent to the County Clerk of Court would include:
- a) Lien Letter
  - b) Lien or updated lien
  - c) Copy of lien to be time stamped and sent back by the clerk of court
  - d) Self-addressed stamped envelope to route time-stamped lien copy back to IME Revenue Collections
  - e) Confidential SSN Form
- Step 22:** Notification sent to Attorney or Insurance Company would include:
- a) Subrogation letter
  - b) Lien or updated lien
  - c) Related claims history pages upon receipt of valid authorization. Valid authorization forms are also required to release claims history for restitution cases.
  - d) Copy of the Iowa Medicaid Recovery Worksheet
- Step 23:** Notification sent to an unrepresented Medicaid Member would include:
- a) Copy of the County Clerk of Court transmittal letter and lien form
  - b) Copy of the subrogation letter sent to the insurance company or liable third party
  - c) Copies of the related claims history printout and lien information sheet will also be sent if applicable
- Step 24:** All correspondence is printed and retained in case file
- Step 25:** Lien Amount Settlement Negotiations occur when disputed by the liable third party or member's legal representative. Research is done to determine if related claims were the result of an injury. Exchanges

- correspondence with attorney and liable third party until final settlement amount is negotiated.
- Step 26:** If claim was included in error, adjust the lien amount and send notice to:
- a) Attorney
  - b) Insurance Company
  - c) Clerk of court
- Step 27:** Lien Recovery checks sent by attorneys, insurance companies and others are indexed in OnBase, and then processed into the Maestro system. If the check amount is equal to the full lien amount, the liable party can be released from the lien.
- a) Lien Recovery checks indexed in OnBase
  - b) Check copies are printed and given to caseworker
  - c) Caseworker reviews claims in Maestro and post payments
  - d) Caseworker processes the Lien Release and forwards to County Clerk of Court, Attorney or Insurance Company
- Step 28:** Compare check amount against lien amount in the case file and Maestro
- Step 29:** If the check amount and lien amount do not match, the Caseworker contacts the attorney and/or insurance company involved with the case to investigate the discrepancy
- Step 30:** The Caseworker will close the case in Maestro if the check amounts and lien amounts match
- Step 31:** The Caseworker will place a copy of the check and documentation into the hard copy file housed at the IME
- Step 32:** The Caseworker will mail the original, notarized Release of Lien to the appropriate Clerk of Court and mail a copy to the attorney or insurance company
- Step 33:** The Lien Recovery Supervisor pulls a Maestro Report and reviews 3% of cases closed by the Lien Recovery Caseworkers on a monthly basis utilizing the Lien Recovery Case Audit Criteria
- Step 34:** The Lien Recovery Supervisor provides a copy of the results noted on the Lien Recovery Case Audit Criteria. The Caseworker is then required to perform any corrective measures needed to ensure the accuracy of information in the hard copy case file and Maestro. The Q.A. results are noted on the Monthly Lien Recovery Q.A. Report
- Step 35:** The Revenue Collections Account Manager or Operations Manager will advise the State Revenue Collections Unit Manager and the Department of Human Services (DHS) Caseworker of any suspected member fraud in instances where a member received funds from a liable third party specifically marked for payment of provider claims related to a trauma incident and payment was not made to the provider
- Step 36:** The Revenue Collections Account Manager or Operations Manager will advise the State Revenue Collections Unit Manager of any suspected

fraud in instances where a provider received payment for trauma related claims from a liable third party, in addition to receiving payment for the same claims by Medicaid, then failing to reimburse Medicaid.

**Forms/Reports:**  
**Lien Recovery Flow Chart**





## Request for Lien Amount and Claims Summary Printout

## SHANKS LAW FIRM

RANDALL J. SHANKS

409 WEST BROADWAY  
COUNCIL BLUFFS, IOWA 51503  
PHONE: (712) 322-2600 ~ FAX: (712) 323-5577  
FED TAX ID #42-1350113

LICENSED IN  
IOWA & NEBRASKA

If there is a problem with transmission or if all pages are not received, please call 322-2600 for retransmission.

TO: Iowa Medicaid Enterprise  
Lien Recovery/Revenue Collections

FAX #: 515-725-1352

OF:

DATE: April 11, 2006

FROM: Brenda Baier, B.A., Paralegal

RE: Lamb, Marilyn vs. Amercian Family

Number of Pages: 3

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is PRIVILEGED, CONFIDENTIAL and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return the original to us by mail without making a copy. Thank you.

### Comments:

Please be advised that we represent Marilyn Lamb concerning her claim for injuries arising out of a December 27, 2005 automobile accident. Mrs. Lamb's injuries consisted of a cervical, thoracic and lumbar strain.

Would you please provide us with your current lien balance and an itemization of the medical bills that you have paid? I am attaching an authorization allowing you to release information to us.

For your information, we are in the process of submitting a settlement demand letter to the American Family.

Should you have any questions, please feel free to contact me.

Thanks,

Brenda

Authorization to Release Information Form



**II. AUTHORIZATION FOR CONSULTATION**

I understand that if the person or entity listed above is a physician, surgeon, physician's assistant, advanced registered nurse practitioner or mental health professional (provider) this authorization also permits \_\_\_\_\_ [insert name of attorney requesting consultation] to consult with that provider about my medical history and condition relating to my claims described above, and further permits that health professional to render opinions regarding the cause of my condition and the prognosis for that condition. I understand that if the lawyer seeking consultation represents a party adverse to me, that lawyer shall provide a written notice to my lawyer and other counsel consistent with the Iowa Rules of Civil Procedure for service of a notice of deposition at least ten (10) days prior to such consultation.

In order for the above consultation to be authorized, sign here and at the end of Section I

\_\_\_\_\_  
Signature of Patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and relationship of patient's legal representative:

**III. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION**

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes.]

\_\_\_\_\_ Substance Abuse (Drug or Alcohol) Information from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Name of agencies, facilities, or individuals)

Mental Health Information from:

NOTE: You have the right to inspect the disclosed mental health information at any time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Name of agencies, facilities, or individuals)

\_\_\_\_\_ AIDS-related Information, Diagnosis, and test results from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Name of agencies, facilities, or individuals)

\_\_\_\_\_  
Signature of Patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name and relationship of patient's legal representative:

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to all of the persons referred to in the Redisclosure Section I.

In order for the above information to be released, you must sign here AND at the end of Section I. If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.

\_\_\_\_\_  
Signature of Patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name and relationship of patient's legal representative:

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

## Trauma Code Lead Letter

RETURN TO:  
IOWA MEDICAID ENTERPRISE  
P.O. BOX 36446  
DES MOINES, IA 50315  
2/24/2007

STATE OF IOWA  
DEPARTMENT OF HUMAN SERVICES  
Date of incident: 1/15/2006 SID#: 1111111A  
Name of person involved: MICKEY MOUSE  
Provider: 7777777 DOCTOR ONE

Dear Medicaid Member:

Federal law requires that Medicaid pursue all possible sources of funding that are available to pay for services. Medicaid had paid bills related to this injury. We now need to know how the injury happened. Please complete this form and return it WITHIN TEN (10) DAYS. Please answer all questions, indicating N/A if the question is not applicable. Failure to complete and return this form could result in the loss of your Medicaid benefits. If the injured person is a minor, the parent or guardian acting on his/her behalf must complete this form. Thank you for your cooperation.

1. Do you have any health insurance other than Medicaid? YES NO

If yes, what is the name of the insurance company?

What is the address of the insurance company?

What is the policy number?

Have you submitted a claim to the insurance company? YES NO

If so, how much have they paid? To whom?

2. Was your injury the result of:  
A. a motor vehicle accident? (Please go to section A)  
B. a fall, fire, assault, fight or other (Please go to section B)

### SECTION A (FOR MOTOR VEHICLE ACCIDENTS)

A1. Please give the date of the accident:  
Briefly explain what happened.

A2. Were there other members of your family who were injured? YES NO  
If so, please write their full names here.

A3. Were you a passenger\_\_\_\_, driver\_\_\_\_ or pedestrian\_\_\_\_?

A4. If you were a driver or passenger, who owns the vehicle in which you were riding?

A5. Does the owner have auto insurance on this car? YES NO  
What is the name of the insurance company?  
What is the address of the insurance company?  
What is the insurance policy number?

#470-0398 (06/05)

OVER ==>



- A6. If another vehicle was involved in this accident or if you were injured as a pedestrian, list the name and address of the vehicles owner:
- A7. What is the name of this owners insurance company?  
What is the address of this insurance company?  
What is the policy number?
- A8. Who was determined to be at fault or issued a ticket?
- A9. Do you have car insurance,(regardless of its involvement in this accident)?  
If yes, what is the name of the insurance company.  
What is the policy number?  
What is the insurance companys address?
- A10. Have you retained an attorney as the result of this accident?  
If so, what is the attorneys name?  
Telephone number?  
What is the attorneys address?

SECTION B (FOR FALLS, ASSAULTS, FIRES, AND OTHER ACCIDENTS)

- B1. Please give the date of the injury:  
Briefly explain what happened:
- B2. Where did your injury occur? please include the address:
- Is this your place of residence? YES NO
- Who owns the property?
- Does the owner have homeowners or property insurance? YES NO
- If yes, what is the name of the insurance company?
- What is the policy number?
- What is the address of the insurance company?
- B3. Did your injury occur at work? YES NO
- If yes, what is the name of the workers compensation insurance company?
- What is the address of the insurance company?
- Have you submitted a claim to the insurance company?
- If so, how much was paid? To whom?
- B4. Have you retained an attorney as the result of this injury? YES NO
- If so, what is the attorneys name?  
Telephone number?  
What is the attorneys address?

Your signature \_\_\_\_\_ DATE \_\_\_\_\_  
Telephone number where you can be reached \_\_\_\_\_

Please contact Member Services at (515)725-1003 (Des Moines local) or (800)338-8366 (outside of Des Moines) if have any questions regarding this form.

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Notice of Lien Letter



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**STATE OF IOWA**

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**CHESTER J. CULVER, GOVERNOR**  
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

DATE

Attorney or Insurance Carrier

IME Case No.:

State Client:

SID Number:

Date of Injury:

Dear

The Iowa Department of Human Services (DHS) has been advised that you may be representing and/or liable to the above-named individual(s) for injuries resulting from an incident that occurred on or about **DATE**.

When the above-referenced recipient's application was made for benefits through the Iowa Medicaid Program, an assignment was made to the State of Iowa. The assignment requires the Medicaid recipient to reimburse the State of Iowa for any amount paid by the Medicaid Program that is the responsibility of any liable third party.

You are hereby placed on notice that a lien in the amount of **DOLLARS** has been filed with the Clerk of Court in **BLANK** County. Please note that Iowa Code Sec. 249A.6(1) also states, *"The third party shall obtain a written determination from the department (Iowa Department of Human Services) concerning the amount of the lien before a settlement is deemed final for purposes of this section. A compromise, including but not limited to a settlement, waiver or release of a claim under this section does not defeat the department's (Department of Human Services) lien..."*

We believe these claims are directly related to the incident of **DATE**. We also believe these funds are the liability of a third party and, therefore, reimbursable to the Iowa Department of Human Services. As claims are accrued, we will continue to send an updated status report of the amount due to the Iowa Department of Human Services. We are unable to send you a copy of a detailed claims statement without a completed and signed authorization.

Also enclosed is a Lien Recovery Information Form. If you have not already done so, please complete this form and return it to Iowa Medicaid Enterprise at the address listed below.

Thank you for your cooperation in this matter. If you should have any questions, please contact our office.

Sincerely,

Caseworker

CC: Unrepresented Medicaid Member

Enclosures

Interim Lien Letter

Lien Recovery Manual



# STATE OF IOWA

**CHESTER J. CULVER, GOVERNOR**  
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

DATE

Attorney/Insurance Carrier

IME Case Number:

State Client:

SID Number:

Date of Injury:

Dear

Enclosed herein please find a summary of charges paid by the Iowa Department of Human Services (DHS) in evidence of Medicaid expenditures made incidental to a legal action or claim involving the above-named Medicaid recipient.

The amount of medical expenditures to date is:

\$ \_\_\_\_\_

This is an INTERIM amount.

As claims accrue, we will continue to send an updated status report of the amount due the Iowa Department of Human Services.

Thank you for your cooperation in this matter. If you should have any questions with regard to this matter, please contact the Iowa Lien Recovery Unit.

Sincerely,

Case Worker Name

Case Worker

Enclosures

cc: Unrepresented Medicaid Member

Initial Transmittal Lien Filing Letter



# STATE OF IOWA

**CHESTER J. CULVER, GOVERNOR**  
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

DATE

County Clerk

IME Case Number:  
State Client Name:

Date of Injury:

Dear Clerk of Court:

When the above-named recipient applied for benefits through the Iowa Medicaid Program, an assignment was made to the State of Iowa. The assignment requires the Medicaid recipient to reimburse the State of Iowa for any amount paid by the Medicaid Program that is the responsibility of any liable third party. We believe that claims have occurred which are the liability of a third party for the above-referenced Medicaid recipient. Pursuant to Iowa Code Sec. 249A.6(1), *"When payment is made by the department [Department of Human Services] for medical care or expenses through the medical assistance program on behalf of a recipient, the department [Department of Human Services] shall have a lien, to the extent of those payments, upon all monetary claims which the recipient may have against third parties."*

Enclosed is the original and one copy of the lien. Please file-stamp both the original and one copy. The original should be placed on file. Please return the file-stamped copy to me in the enclosed, self-addressed stamped envelope.

Sincerely,

Case Worker Name  
Case Worker

Enclosures

cc: Unrepresented Medicaid Member

**IN THE IOWA DISTRICT COURT FOR \_\_\_\_\_ COUNTY**

\_\_\_\_\_) )  
\_\_\_\_\_) )  
Plaintiff(s) /Petitioner(s), )  
vs. ) Case No. \_\_\_\_\_ )  
\_\_\_\_\_) )  
Defendant(s) / Respondent(s), ) **CONFIDENTIAL SOCIAL SECURITY NUMBER FORM**

Please note: This form is for the submission of social security numbers ONLY. Dates of birth and employer identification numbers are not confidential and should appear on the heading or face of the petition, answer, etc. Please print or type all information.

	<u>Name</u>	<u>Social Security Number</u>
Plaintiff(s) / Petitioner(s)	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____
	5. _____	_____
Defendant(s) / Respondent(s)	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____
	5. _____	_____
Other Parties	1. _____	_____
	2. _____	_____
	3. _____	_____

Information supplied by \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Lien Form

County Clerk of Court

NOTICE OF MEDICAL ASSISTANCE (MEDICAID OR TITLE XIX) LIEN  
(Iowa Code Sec. 249A.6 as amended by 89 S.F. \_\_\_\_ effective July 1, 1995)  
in favor of the  
IOWA DEPARTMENT OF HUMAN SERVICES  
Hoover Building, Des Moines, IA 50319

County:

Case No.:

Recipient:

Address:

Recipient SSN.: (THIS FIELD IS TO BE LEFT BLANK)

Recipient ID: (THIS FIELD IS TO BE LEFT BLANK)

Lien Against Liable Third Party:

Insurance Company (If Applicable):

IME Case No.:

Recipient's Attorney (If Applicable):

Defendant's Attorney (If Applicable):

Date of Loss:

Current Amount of Lien:

I certify under the penalty of perjury and pursuant to the laws of the State of Iowa (Iowa Code Sec. 622.1) that the preceding is true and correct. Dated: \_\_\_\_\_.

---

CASEWORKER NAME  
IOWA MEDICAID ENTERPRISE  
Revenue Collections/Lien Recovery Unit  
(888) 543-6742

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Updated Transmittal Lien Filing Letter



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**STATE OF IOWA**

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**CHESTER J. CULVER, GOVERNOR**  
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

DATE

Clerk

IME Case Number:  
State Client:

Date of Injury:

Dear Clerk of Court:

The Iowa Lien Recovery Unit previously filed a lien on behalf of the Iowa Medicaid Program. Since that time, adjustments to the lien amount have been made. Attached is an original and one (1) copy of the updated lien, which includes the additional amount due to the State of Iowa on behalf of the Iowa Medicaid Project. Please file-stamp both the original and one (1) copy. The original should be placed on file. Please return the file-stamped copy to the Iowa Lien Recovery Unit in the enclosed self-addressed, stamped envelope.

Thank you for your cooperation in this matter. If you should have questions with regard to this matter, please contact the Iowa Lien Recovery Unit.

Sincerely,

Case Worker Name  
Case Worker

Enclosures

cc: Unrepresented Medicaid Member

County Clerk of Court

**UPDATED LIEN**

NOTICE OF MEDICAL ASSISTANCE (MEDICAID OR TITLE XIX) LIEN  
(Iowa Code Sec. 249A.6 as amended by 89 S.F. \_\_\_\_ effective July 1, 1995)  
in favor of the

IOWA DEPARTMENT OF HUMAN SERVICES  
Hoover Building, Des Moines, IA 50319

County:

Case No.:

Recipient:

Address:

Recipient SSN.: (THIS FIELD IS TO BE LEFT BLANK)

Recipient ID: (THIS FIELD IS TO BE LEFT BLANK)

Lien Against Liable Third Party:

Insurance Company (If Applicable):

IME Case No.:

Recipient's Attorney (If Applicable):

Defendant's Attorney (If Applicable):

Date of Loss:

Current Amount of Lien:

I certify under the penalty of perjury and pursuant to the laws of the State of Iowa (Iowa Code Sec. 622.1) that the preceding is true and correct. Dated: \_\_\_\_\_.

\_\_\_\_\_  
CASEWORKER NAME  
IOWA MEDICAID ENTERPRISE  
Revenue Collections/Lien Recovery Unit  
(888) 543-6742

Case Information Form

Iowa Department of Human Services  
Iowa Medicaid Enterprise (IME)  
Revenue Collections

Iowa DHS Lien Recovery Information Form

Medicaid Recipient (Injured Party) Information

Name MCNELLY, BRITTNEY  
Social Security Number 484178684 Date of Birth 1990-03-15  
Medicaid Id / Billing Number 1465827J

Accident/Incident Information

Accident/Incident Date 2005-12-12 Last Date of Medical Service \_\_\_\_\_ Has a lawsuit been filed? \_\_\_\_\_  
Accident/Incident Type (Check appropriate type)  
Automotive \_\_\_\_\_ Slip and Fall \_\_\_\_\_ Malpractice \_\_\_\_\_ School-based \_\_\_\_\_  
Assault \_\_\_\_\_ Home-owners \_\_\_\_\_ Work Related \_\_\_\_\_ Dog Bite \_\_\_\_\_ Other/Unknown \_\_\_\_\_

Describe the accident and injuries (include body parts injured):

Head/Face  Neck/Throat  Shoulder  Back/Spine  Chest  Upper Leg  Knee   
Elbow  Upper Arm  Hands  Lower Arm  Hip  Lower Leg  Foot

Name(s) of Medical Person/Facility That Provided Medical Services: \_\_\_\_\_ Date(s) Service Provided \_\_\_\_\_  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Liable Person(s) Involved Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Liable Insurance Company Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Adjuster Name \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Maximum Liability \_\_\_\_\_

Defense Attorney Information

Name \_\_\_\_\_  
Firm \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax \_\_\_\_\_  
Email Address \_\_\_\_\_  
Client Name \_\_\_\_\_

Plaintiff Attorney Information

Name \_\_\_\_\_  
Firm \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax \_\_\_\_\_  
Email Address \_\_\_\_\_  
Client Name \_\_\_\_\_



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
EUGENE J. GESSOW, DIRECTOR

JANETTE GROFFENUSCHEN  
WEBSTER COUNTY CLERK  
WEBSTER COUNTY COURTHOUSE  
701 CENTRAL AVE.  
FORT DODGE, IA 50501

IME Case Number: 109306  
State Client: HEATHER MILLER

Date of Injury: 07/02/2006

Dear Clerk of Court:

Attached please find the Release of Lien regarding the above referenced individual. Please file stamp both the original and one (1) copy. The original should be placed on file. Please return the file stamped copy to the Iowa Lien Recovery Unit in the enclosed self-addressed, stamped envelope.

Thank you for your cooperation in this matter. If you should have questions with regard to this matter, please contact the Iowa Lien Recovery Unit.

Sincerely,

Carrie Kleis,  
Case Worker

CC to:

Enclosures

Iowa Department of Human Services  
Iowa Medicaid Enterprise (IME)  
Revenue Collections

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JANELLE GROTELUSCHEN  
WEBSTER County Clerk of Court  
WEBSTER COUNTY COURTHOUSE  
701 CENTRAL AVE  
FORT DODGE, IA 50501

RELEASE OF  
MEDICAL ASSISTANCE (MEDICAID OR TITLE XIX) LIEN  
(Iowa Code Sec. 249A.6 as amended by 88 S.F. Effective July 1, 1995)  
in favor of the  
IOWA DEPARTMENT OF HUMAN SERVICES  
Hoover Building Des Moines, Iowa 50319

County: WEBSTER Case No.:

Recipient:  
Address:

Recipient SSN:  
Recipient ID:

Lien against liable third party:  
Insurance Company (if Applicable) PROGRESSIVE INSURANCE  
IME Case No. 103206  
Recipient's Attorney (if applicable):  
Defendant's Attorney (if applicable):

Date of Loss: 07/02/2005  
Current amount of lien: \$31,340.95

As of May 17, 2007 this lien was satisfied in full

I certify under the penalty of perjury and pursuant to the laws of the State of Iowa (Iowa Code Sec. 622.1) that the preceding is true and correct. Dated: May 17, 2007.

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Carrie Klein  
IOWA MEDICAID ENTERPRISE  
Revenue Collections/Lien Recovery Unit  
(888) 541-5747

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NOTE: Iowa Code Sec. 249A.6(1), as amended provides in part that the third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final for purposes of this section. This claim cannot be released by the injured person or the injured person's attorney. Any payment made by the liable third party or on behalf of the liable third party without the disposing of this claim can subject the liable third party and/or their attorney to the risk of double liability.

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Iowa Medicaid Recovery Worksheet

## Lien Recovery Worksheet

Total Settlement Amount \_\_\_\_\_

Deduct Attorney Fee \_\_\_\_\_

Deduct Docketed Court Costs \_\_\_\_\_

Balance Remaining \_\_\_\_\_

Divide the balance remaining by 3

1/3 Balance Paid To Recipient\* \_\_\_\_\_

2/3 Balance Subject to Medicaid Lien \_\_\_\_\_

If a lien amount is greater than the 2/3 balance, Medicaid will accept the lesser of the two amounts

### Example calculation:

Ms. Smith has a medical lien of \$2,000.00. Her settlement amount is \$10,000.00, the attorney's fee is 1/3<sup>rd</sup> and the docketed court costs are \$150.00. The calculation is as follows to determine the reimbursement amount:

Total Settlement Amount \$10,000.00

Deduct Attorney Fee \$3,334.00

Deduct Docketed Court Costs \$150.00

Balance Remaining \$6,516.00

Divide the balance remaining by 3 ( $\$6,516.00/3=\$2,172.00$ )

1/3 Balance Paid To Recipient \$2,172.00

2/3 Balance Subject to Medicaid Lien \$4,344.00

\*Any advanced expenses or non-docketed court costs (i.e. photo copies, deposition, etc.) come out of these funds.

Provider Reimbursement Request Letter



## STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

DATE

PROVIDER NAME  
DEPT.  
STREET ADDRESS  
CITY, STATE ZIP

CASE NO.  
MEMBER:  
MEDICAID ID NO.:  
DATE OF INCIDENT:  
CLAIM NO.:

Dear Sir/Madam:

We have been advised that your facility received payment from a third party for services provided on behalf of the above-referenced Medicaid member. Your facility also submitted a claim to Medicaid for these same dates of service and Medicaid made payment in the amount of \$\_\_\_\_\_. Pursuant to 441 Iowa Administrative Code 79.2(249A), Medicaid is the payer of last resort and must be reimbursed in the amount of \$\_\_\_\_\_.

Payment should be made to ***Iowa Medicaid Enterprise*** and mailed to:

Revenue Collections/Lien Recovery Unit  
P.O. Box 36446  
Des Moines, IA 50315

Please include a copy of this letter so your payment will be posted to the correct account.

If you have already issued a refund to Medicaid, please send the supporting documentation, along with a copy of this letter in order that the appropriate claims can be adjusted.

If you have any questions, please contact the Lien Recovery Unit at 515-256-4620 or toll free at 888-543-6742. Your cooperation in this matter is appreciated.

Sincerely,  
Revenue Collections Unit

470-4502 (12/07)

Civil Case Subrogation Notice



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# STATE OF IOWA

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**CHESTER J. CULVER, GOVERNOR**  
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES  
Charles J Krogmeier, DIRECTOR

February 27, 2015

Law Firm  
STREET ADDRESS  
CITY, STATE ZIP

IME Case Number: 100000  
State Client: (Client Name)  
SID#: (SID Number)  
Date of Injury: 03/01/2002

Dear Sir/Madam:

The Iowa Department of Human Services (DHS) has been advised that you may be representing the above named individual(s) for injuries resulting from an incident that occurred on or about (Date, Month, Year).

When the above-referenced recipient's application was made for benefits through the Iowa Medicaid program, an assignment was made to the State of Iowa. The assignment requires the Medicaid recipient to reimburse the State of Iowa for any amount paid by the Medicaid program that is the responsibility of any liable third party.

You are hereby placed on notice that Iowa Medicaid has paid claims totaling (Insert Dollar Amount) on behalf of (Client Name). We believe these claims to be directly related to the incident on (date or number). We also believe these funds are the liability of a third party and therefore, reimbursable to the Iowa Department of Human Services. We are unable to send you a copy of a detailed claims statement without a completed and signed authorization.

Thank you for your cooperation in this matter. If you should have questions with regard to this matter, please contact the Iowa Lien Recovery Unit.

Sincerely,

(Case Worker Name),  
Case Worker

Notice of Lien Settlement to Payment to Medicaid Member

**Notice of Lien Settlement Payment to Medicaid Member**

**Income Maintenance Worker Information**

County: \_\_\_\_\_

Worker ID: \_\_\_\_\_

**Medicaid Member Information**

Name: \_\_\_\_\_

State ID: \_\_\_\_\_

**Lien Settlement Information**

Name and address of third-party insurer or liable third party (if known):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Amount of settlement (paid to member), including other terms (ex. non-recurring lump-sum, recurring payments, payments to a trust, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Issue date of check (if known): \_\_\_\_\_

Date check sent to member (if known): \_\_\_\_\_

Member Attorney Information (if any):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_

**IME Revenue Collections Contact Information**

Name: \_\_\_\_

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Iowa Lien Report**

Last Name	First Name	State ID	Case Number	Date of Accident	Responsible Party

Case Open Date	Amount of Lien	Amount Recovered	Date Check Received	Payment Type

**Alborn Tracking Report:**

Name	Case/Incident Number	Case Opened	Lien/Claim Amount	Total Case Settlement Amount	Total Case Value / Total Damages Asserted (if known)	\$ Potentially Recovered Pre Alborn	\$ Actually Recovered Post Alborn	\$ Loss From Alborn	Case Closed

**RFP References:**

N/A

**Interfaces:**

N/A

**Attachments:**

N/A

**Acronyms:**

**IME:** Iowa Medicaid Enterprise

**HMS -** Health Managements Systems The corporation contracted by Iowa Medicaid Enterprise to perform revenue collections functions.

**Lien Recovery Caseworker (Caseworker):** a Revenue Collections Unit staff member assigned to work casualty recovery cases.

**MMIS Recipient History Profile (MMIS Report):** Report IAMC9500-R001 generated from the MMIS System by the Core Unit.

**Lien:** Notice of Medical Assistance (Medicaid or Title XIX) Lien

**Maestro:** HMS proprietary case management system