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Dodge v. Bruccoli and its Progeny - Lifetime Medical Care?

Dodge v. Bruccoli

Dodge suffered a back injury in a non-work related incident and underwent surgery. He then reinjured his back in a work related incident while he was recovering from the surgery. Dodge had two subsequent back surgeries and was referred to a pain management program. The physician overseeing the program found that Dodge had reached maximum medical improvement and assigned a 30% impairment rating to the lumbar spine. The physician testified that Dodge would probably need treatment and maintenance medication for the rest of his life or his period of disability would increase. *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 S.C. 574 (S.C. Ct. App. 1999).

The procedural history of this case is somewhat complicated. In short, the Commission awarded Dodge continuing medical benefits finding as a matter of law that S.C. Code Ann. §42-15-60 (1985) provided for ongoing treatment and medication as long as such would lessen the period of disability. This award was based on a finding that Dodge would not be working but for his receipt of the additional medical treatment and medication. The Circuit Court affirmed the Commission's order and Bruccoli appealed. The Court of Appeals affirmed this part of the Circuit Court's decision, holding that, "an employer may be liable for a claimant's future medical treatment if it tends to lessen the claimant's period of disability despite the fact that claimant has returned to work and has reached maximum medical improvement." *Dodge*, 334 S.C. at 583.

At the time of this case, S.C. Code Ann. §42-15-60 stated "in pertinent part, 'Medical, surgical,

hospital, and other treatment, including medical and surgical supplies as may reasonably be required, for a period not exceeding ten weeks from the date of an injury to effect a cure or give relief and *for such additional time as in the judgment of the Commission will tend to lessen the period of disability*.... In case of a controversy arising between employer and employee, the Commission may order such further medical, surgical, hospital or other treatment as may in the discretion of the Commission be necessary.' (emphasis added)" *Dodge*, 334 S.C. at 580 *citing S.C. Code Ann.* §42-15-60 (1985).

The Court of Appeals stated that, "[t]his section clearly 'allows the Commission to award medical benefits beyond 10 weeks from the date of injury only where the Commission determines such medical treatment would tend to lessen the period of disability.'" *Dodge*, 334 S.C. at 580 *citing Sanders v. Litchfield Country Club*, 297 S.C. 339, 344, 377 S.E.2d 111, 114 (Ct. App. 1989). "Disability is defined in the South Carolina Workers' Compensation Act as the 'incapacity because of injury to earn the wages which the employee was receiving at the time of the injury in the same or any other employment.'" *Dodge*, 334 S.C. at 580 *citing S.C. Code Ann.* §42-1-120 (1985).

"Section 42-15-60 'does not by its terms equate an employer's liability for medical treatment to any other period of liability, for income compensation or otherwise.' The statute defines 'the period of disability in terms of the time period in which the employee is statutorily incapacitated.' Thus, under section 42-15-60 'the employer is liable for medical treatment which will tend to lessen the time in which injury renders an employee incapable 'to earn the wages which the employee was receiving at the time of the injury in the same or other employment.'" *Dodge*, 334 S.C. at 580 *quoting Rice v. Froehling & Robertson, Inc.*, 267 S.C. 155, 159, 226 S.E.2d 705, 706 (1976).

"Section 42-15-60 specifically refers to the term 'disability' and makes no reference to maximum medical improvement. Given the statutory language and our Supreme Court's construction of it, a finding that Dodge reached maximum medical improvement had no bearing on the determination of

whether Bruccoli was liable for medical treatment beyond the ten week time period. 'Maximum medical improvement' is a distinctly different concept from 'disability.'" *Dodge*, 334 S.C. at 581.

"'Maximum medical improvement is a term used to indicate that a person has reached such a plateau that in the physician's opinion there is no further medical care or treatment which will lessen the degree of impairment.'" *Dodge*, 334 S.C. at 581 *quoting O'Banner v. Westinghouse Elec. Corp.*, 319 S.C. 24, 28, 459 S.E.2d 324, 327 (Ct. App. 1995). "However, the fact that a claimant has reached maximum medical improvement does not preclude a finding the claimant still may require additional medical care or treatment." *Dodge*, 334 S.C. at 581 *citing Scruggs v. Tuscarora Yarns, Inc.*, 294 S.C. 47, 362 S.E.2d 319 (Ct. App. 1987). "Although this medical care or treatment may not reduce the claimant's degree of physical impairment, it may 'tend to lessen the period of disability.'" *Dodge*, 334 S.C. at 581 *quoting Rice v. Froehling & Robertson, Inc.*, 267 S.C. 155, 162, 226 S.E.2d 705, 708 (1976).

The court held that, "an employer may be liable for a claimant's future medical treatment if it tends to lessen the claimant's period of disability despite the fact that claimant has returned to work and has reached maximum medical improvement.... [E]ven if a claimant's physical impairment rating does not change, his or her earning capacity may be reduced without the benefit of further medical care and treatment." *Dodge*, 334 S.C. at 583.

Adkins v. Georgia-Pacific

Adkins suffered an injury to her right ear in the course of and arising out of her employment. Adkins' physician determined that she had reached maximum medical improvement with no permanent disability. However, the injury lead to a weakening of the tympanic membrane, causing a small hole to appear from time to time, leading to chronic ear infections. The physician testified that these infections could be controlled with medication, allowing Adkins to work at her normal occupation without interruption. *Adkins v. Georgia-Pacific*, 350 S.C. 34, 564 S.E.2d 339 (S.C. Ct. App. 2002).

The Commissioner ruled that, although Adkins had no permanent physical disability, she was nevertheless entitled to ongoing medical benefits for her chronic condition. Georgia-Pacific appealed to the Circuit Court , arguing that S.C. Code Ann. §42-15-60 "only allows for future medical costs beyond ten weeks when the commission finds these benefits will tend to lessen the period of disability." Adkins, 350 S.C. at 36. The Circuit Court ruled that Adkins was not entitled to future medical costs because she suffered no disability and Adkins appealed from that decision.

The Court of Appeals stated that, "[o]nce it is determined the claimant suffered a compensable injury, South Carolina law provides future medical costs can be awarded if the commission determines the award will tend to lessen the time during which the claimant is unable to earn, in the same or other employment, the wages he or she received at the time of the injury." *Adkins v. Georgia-Pacific Corp.*, 350 S.C. 34, 37 (S.C. Ct. App. 2002) *citing S.C. Code Ann.* § 42-15-60 (1985); *Rice v. Froehling & Robertson, Inc.*, 267 S.C. 155, 159, 226 S.E.2d 705, 706 (1976); *Dykes v. Daniel Constr. Co.*, 262 S.C. 98, 110, 202 S.E.2d 646, 652 (1974). The court then cited it's previous decision in *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 S.C. 574 (S.C. Ct. App. 1999), where it upheld "the commission's conclusion that future medical treatment would tend to lessen the time during which the claimant would be statutorily incapacitated." Relying on these precedents, the Court of Appeals reversed the Circuit Court, finding that "the evidence supports the full commission's finding that even though Adkins is not disabled, future medical treatment would tend to lessen her period of disability by keeping her from becoming disabled." *Adkins v. Georgia-Pacific Corp.*, 350 S.C. at 38.

Hall v. United Rentals

Hall suffered a back injury while working for United Rentals and underwent several back surgeries as a result. Following the surgeries, Hall underwent knee surgery and treatment for depression secondary to his chronic back pain. United denied compensability for the knee surgery and depression

treatment. "[T]he single commissioner found the injury to Hall's right leg and depression were causally related to the work injury. The Appellate Pannel adopted the findings of the single commissioner and ordered payment of expenses related to the right leg injury and depression. The circuit court affirmed." *Hall v. United Rentals, Inc.*, 371 S.C. 69 (S.C. Ct. App. 2006). Hall continued to experience back pain and underwent several additional surgeries despite United's denial of authorization. The single commissioner found that the treatment was necessary and tended to lessen Claimant's disability, concluding that Hall had not reached maximum medical improvement and ordering United to pay all causally related medical treatment from the date of Claimant's accident and continuing. The Appellate Panel adopted the conclusions of the single commissioner and the circuit court affirmed.

The Court of Appeals noted that, "the panel is afforded much discretion under Section 42-15-60," which had been amended in 2005 and provides in pertinent part, "[m]edical, surgical, hospital and other treatment, including medical and surgical supplies as may reasonably be required, for a period not exceeding ten weeks from the date of an injury to effect a cure or give relief and for such additional time as in the judgment of the Commission will tend to lessen the period of disability and.... In case of a controversy arising between employer and employee, the Commission may order such further medical, surgical, hospital or other treatment as may in the discretion of the Commission be necessary." *Hall*, 371 S.C. at 81; *quoting S.C. Code Ann.* §42-15-60 (2005).

The Court of Appeals noted that this state has a rich jurisprudential history with respect to medical care and proceeded to review the holdings of the key decisions in this area. "The medical benefits provision of the Workers' Compensation Act allows the Appellate Panel to award medical benefits beyond ten weeks from the date of injury only where it determines such medical treatment would tend to lessen the period of disability." *Hall*, 371 S.C. at 82 *citing Dykes v. Daniel Const. Co.*, 262 S.C. 98, 202 S.E.2d 646 (1974); *Williams v. Boyle Const. Co.*, 252 S.C. 387, 166 S.E.2d 550

(1969); *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 S.C. 574, 514 S.E.2d 593 (Ct. App. 1999). "Generally, even though a claimant has reached maximum medical improvement (MMI), if additional medical care or treatment would 'tend to lessen the period of disability,' then the Appellate Panel may be warranted in requiring such treatment to at least maintain the claimant's degree of physical impairment. *Hall*, 371 S.C. at 82 *quoting Lee v. Harborside Café*, 350 S.C. 74, 81, 564 S.E.2d 354, 358 (Ct. App. 2002). "However, the fact a claimant has reached maximum medical improvement does not preclude a finding the claimant may still require additional medical care or treatment." *Hall*, 371 S.C. at 82 *quoting Dodge*, 334 S.C. at 581, 514 S.E.2d at 596. "Therefore, 'an employer may be liable for a claimant's future medical treatment if it tends to lessen the claimant's period of disability despite the fact the claimant has returned to work and has reached [MMI].' *Hall*, 371 S.C. at 82 *quoting Lee*, 350 S.C. at 81, 564 S.E.2d at 358.

The Court of Appeals held that, "the Appellate Panel's decision to require additional medical treatment that tended to lessen Hall's period of disability and provided some relief for his intractable pain is in accord with the discretion authorized in section 42-15-60. Though Hall remained essentially disabled, the additional treatment improved his overall quality of life and ability to cope." *Hall*, 371 S.C. at 85.

What is the State of "Dodge Medicals" today?

Clearly the *Dodge* decision and its progeny has expanded the scope of liability that an employer is exposed to with respect to employer liability for medical treatment after maximum medical improvement. Where *Dodge* held that an employer may be liable for a disabled claimant's future medical treatment if it tended to lessen the claimant's period of disability, *Adkins* went even further in holding that an employer may be liable for a claimant's future medical treatment if it tended to keep the claimant from becoming disabled. *Hall* demonstrated the wide latitude that the courts will give the

Commission in awarding continuing medical treatment pursuant to their discretion as provided for in the statute.

"The number of lifetime medical reimbursements have increased exponentially since *Dodge*..." 19 S. Carolina Lawyer 17 (2008). *In fact, "Dodge* is often cited with regard to a request or award involving lifetime medical care, [which are] now commonly referred to as '*Dodge* medicals.'" 19 S. Carolina Lawyer 24 (2008). While current figures are not available at this time, previous reports have suggested that the Commission has embraced the concept of Dodge medicals and has been consistently awarding them where warranted.

Change of Condition - How do We Prove it and Defend Against it?

S.C. Code Ann. §42-17-90 (2009) states that, "[o]n its own motion or on the motion of a party in interest on the ground of a change in condition, the commission may review an award and on that review may make an award ending, diminishing, or increasing the compensation previously awarded, on proof by a preponderance of the evidence that there has been a change of condition caused by the original injury, and after the last payment of compensation." Furthermore, the statute states that, "...the review must not be made after twelve months from the date of the last payment of compensation pursuant to an award provided by this title." *Id*. A number of issues related to this statute have been litigated in the Court of Appeals and Supreme Court of South Carolina. These issues include what constitutes a change of condition, what is the time frame for filing for a change of condition, what constitutes compensation, and what is the burden of proof in establishing a change of condition.

The significant case law regarding a change of condition can be broken down into two eras: The Early Era, from 1940 to 1969, and The Modern Era, from 1990 to the present. The earliest case that is commonly cited on the issue of a change in condition is *Cromer v. Newberry Cotton Mills*, 201 S.C. 349, 23 S.E.2d 19 (S.C. 1942). This case stands for the proposition that a change of condition means a change in the physical condition of the claimant as a result of the original injury and occurring after the commission's first award. *Id*. The court included in its decision language from the Circuit Court's order, which expounds on this proposition by noting that, "...in the event of a change in condition, the commission may review any award. No doubt the purpose of this section is to enable the commission to end compensation in cases where the change in condition amounts to a complete recovery; to enable it to diminish compensation where the change in condition is for the better; and to increase compensation where the facts developed upon a review show that the change in condition is for the worse. This

continuing jurisdiction is given so that full justice may be done in any particular case." *Cromer* 201 S.C. 349 (internal quotations omitted).

The Supreme Court maintained its position on what constitutes a change of condition, stating in *Allen v. Benson Outdoor Advertising*, 236 S.C. 22, 25 112 S.E.2d 722, 724 (S.C. 1960) that the central issue is, "whether there has been a worsening of the injury on which the original was based." (internal quotations and citations omitted). In *Allen*, the court also opined on the proper time frame in which an application for change of condition may be filed, holding that it is sufficient under the statute if the application for review was filed within one year from the last date of the last payment of compensation, even if there was no hearing thereon until after the expiration of the one year period. *Allen*, 236 S.C. at 30. The court stated that to rule otherwise would represent, "a literal and strict construction of [the statute] when under the well-settled rule a liberal construction is required." *Id*. To construe the statute otherwise, "would lead to a rather unreasonable result clearly not within the intent of the legislature. An application might be seasonably made but due to crowded dockets or other causes could not be heard within the statutory period." *Id*.

The Supreme Court again expounded on the *Cromer* holding in *Krell v. S.C. State Hwy. Dept.*, 237 S.C. 584, 588, 118 S.E.2d 322, 323 (S.C. 1961), stating that, "[i]f a review of a compensation agreement or settlement is sought on the change of condition of the employee, a change in condition must be shown, and it must be causally connected with the original compensable accident. "In reopening a proceeding, the issue before the commission is sharply restricted to the question of extent of improvement or worsening of the injury on which the original award was based. If claimant sustained injuries at the time of the original action which he knew about at the time of his claim but for some reason failed to include in the claim, he cannot for the first time assert disability from these injuries in a petition based on change of condition. *Krell*, 237 S.C. at 588 (internal quotations omitted).

The physical component of an injury was again stressed by the court in *Causby v. Rock Hill Printing and Finishing Co.*, 249 S.C. 225, 227, 153 S.E.2d 697, 698 (S.C. 1967). "Change of condition, as the term is used in [the statute], means a change in the claimant's physical condition as a result of the original injury, occurring after the first award." *Id*. at 698. The court again commented on the proper time at which the change of condition occurs. "An appeal is concerned with the conditions prior to and at the time of the original Opinion and Award, whereas review under [the statute] is concerned with conditions that have arisen thereafter. *Id*. This was the court's last significant decision regarding a change of condition for a number of years.

The case law on change of condition expanded greatly beginning in the early 1990's. In *Brayboy v. Clark Heating Co.*, 306 S.C. 56, 59 (S.C. 1991), the Supreme Court reiterated its holdings in *Cromer* and *Krell*, stating that, "...a change in condition means a change in the physical condition of the claimant as a result of the original injury, occurring after the first award.... If the claimant sustained injuries...which he knew about at the time of his claim but for some reason failed to include in the claim, he cannot for the first time assert disability for these injuries...based on change of condition." (internal quotations and citations omitted). The court went on to hold that, "...as a matter of law...a claim of change of condition may be based upon undiagnosed conditions, resulting from the original injury, which are discovered after the first award." *Id.* at 59. Stated another way by the court just a year later, "...a claim of change of condition within the meaning of section 42-17-90 may be based upon previously undiagnosed conditions arising from the original injury but not discovered until after a disability settlement. *Mauldin v. Dyna-Color/Jack Rabbit*, 308 S.C. 18, 21 (S.C. 1992)

In *Owenby v. Owens Corning Fiberglas*, 313 S.C. 181, 183 (S.C. Ct. App. 1993), the Court of Appeals stated that review of an award based on change of condition under §42-17-90 is "sharply restricted to the question of extent of improvement or worsening of the injury on which the original

award was based. The statute, therefore, is not applicable to a claim which was not properly compensated." (internal quotations and citations omitted). Thus, where the single commissioner awarded benefits for the loss of twenty-five percent of the claimants finger, but denied benefits for psychological injury and it was not appealed, that matter was barred by the doctrine of res judicata.

The court of appeals returned to the issue of whether a claimant's mental condition may be properly considered as causally connected to his original, compensable claim in *Estridge v. Joslyn Clark Controls*, 325 S.C. 532 (S.C. Ct. App. 1997). "If the mental condition was not causally connected or is a separate injury which could have been included in the original claim, but was not, then it cannot be considered a change in condition. Conversely, if it is causally connected and is a newly manifested symptom of his original injury which has caused a worsening fo his condition, then it is properly considered, and the commission was in error in refusing to do so." *Id*. at 538. The court held that, "[a] condition which is induced by a physical injury, is thereby causally related to that injury" and should be considered by the commissioner in a change of condition hearing. *Id.* The court also addressed the issue of res judicata again, stating that it "only acts to preclude relitigation of issues actually litigated or which might have been litigated in the first action." *Id*. at 539. "A symptom which is present and causally connected, but found not to impact upon the claimant's condition at the time of the original award, may later manifest itself in full bloom and thereby worsen his or her condition. Such an occurrence is within the reasons for the code section involving a change of condition. Therefore it is not barred by res judicata in a change of condition proceeding merely because it was not discussed in the initial award. *Id.*

The Court of Appeals revisited a number of issues associated with a change of condition in *Gattis v. Murrells Inlet VFW # 10420*, 353 S.C. 100 (S.C. Ct. App. 2003). With respect to the actual determination of whether there has been a change in condition, the court stated that, "[t]he determination of whether a claimant experiences a change of condition is a question of fact for the fact

finder. In *Krell*, our Supreme Court stated, it is not the province of this Court to determine whether the greater weight of the evidence supported the finding that a change had taken place in the condition of the claimant as would warrant an extension or enlargement of the award, or whether the greater weight of the evidence supported the finding that such change resulted from injury.... Such facts must be determined by those whose duty it is to find the facts." *Id.* at 107 (internal quotations and citations omitted). The court also addressed when a change of condition claim may properly be brought, stating that, "[g]enerally, an appeal of a worker's compensation order is concerned with the conditions prior to and at the time of the original award of the commission. Review for a change of condition is concerned with conditions that have arisen thereafter.... Review as a change of condition is not available as an alternative to, or substitute for, appeal." *Id.* at 109 (internal quotations and citations omitted). With respect to what constitutes a change of condition, the court stated that, "[a] change of condition occurs when the claimant experiences a change in physical condition as a result of her original injury, occurring after the first award. To justify a modification of an award based on a change of condition, the claimant must show the change of condition and its causal connection to the original compensable accident. The issue before the Commission is sharply restricted to the question of extent of improvement or worsening of the injury on which the original award was based." *Id.* at 109 (internal quotations and citations omitted). Finally, the court addressed the nature of compensation allowed pursuant to the statute, stating that, "[t]he Worker's Compensation Act should be liberally construed in furtherance of the purposes for which it was designed. Any reasonable doubts as to construction should be resolved in favor of the claimant by including him within the coverage of the Act rather than excluding him. It would require a strained construction of the Act to allow a [person] compensation for permanent disability, yet deny him the medical treatment which may prevent his injury from resulting in permanent disability." *Id.* at 111. "[T]he term compensation does not preclude the commission from awarding

medical benefits to the claimant under section 42-17-90." *Id.* Thus, the commission may order both a compensatory award and payment of medical bills.

The Court of Appeals has revisited many of these issues in subsequent cases, often citing the aforementioned cases. *See, e.g. Clark v. Aiken County Gov't*, 366 S.C. 102 (S.C. Ct. App. 2005); *Robbins v. Walgreens & Broadspire Servs.*, 375 S.C. 259 (S.C. Ct. App. 2007); *Mead v. Jessex, Inc.*, 382 S.C. 525 (S.C. Ct. App. 2009); *Mungo v. Rental Unif. Serv. of Florence, Inc.*, 383 S.C. 270 (S.C. Ct. App. 2009).

MSA v. LCP - is There a Conflict, of do We need Both?

Medicare is precluded from paying for a beneficiary's medical expenses when payment has been made or can reasonably be expected to be made under a workers' compensation law or plan of the United States or any of the fifty States. 42 USCS §1395y(B)(2)(A); 42 CFR §411.40. Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. 42 CFR §411.32. Thus, federal law establishes Medicare as a secondary payer to workers' compensation plans. However, Medicare may make conditional payments to a beneficiary when a primary plan has not made or cannot reasonably be expected to make payment promptly, but any such payment is conditioned on reimbursement. 42 USCS §1395y(B)(2)(A); 42 CFR §411.45. This usually occurs when a beneficiary improperly uses Medicare benefits to pay for treatment that should have been covered by the employer. Medicare must be reimbursed for such conditional payments at the time of the settlement.

The burden of future medical expenses in workers' compensation cases may not be shifted to Medicare. Medicare has a priority right of recovery over any other entity to the proceeds of any settlement. If a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment. 42 CFR §411.46.

Because Medicare does not pay for an individual's workers' compensation related medical services when the individual receives a workers' compensation settlement that includes funds for future medical expenses, it is in the best interest of the individual to consider Medicare at the time of the

settlement. The accepted method of doing this is for the parties to a workers' compensation settlement to set aside funds for all future medical services related to the workers' compensation injury that would otherwise be reimbursable by Medicare. Such arrangements are known as a Workers' Compensation Medicare Set Asides or MSA's. A MSA is simply a bank or trust account created for the sole purpose of protecting Medicare from having to pay for expenses that are reasonably related to a workers' compensation related injury. Any portion of the settlement that is allocated to future medical expenses must be set aside in this account and the account must be exhausted before Medicare will step in and pay for future medical treatment.

The Centers for Medicare and Medicare Services, known as CMS, is the federal agency responsible for administering Medicare and, by extension, for enforcing the Medicare Secondary Payer Act. As a result, it is the agency responsible for reviewing all MSA's. A MSA may be submitted to CMS for review and approval if a claimant is a current Medicare beneficiary and the settlement is in excess of $25,000 or if the claimant has a reasonable expectation of enrolling in Medicare within thirty months of the settlement and the settlement is in excess of $250,000. However, this is simply the threshold for CMS review and approval of MSA's and where a claimant is on Medicare the parties need an MSA regardless of the settlement amount. Unfortunately, there is no such bright line rule when the claimant is not on Medicare. The law states that the parties cannot shift reasonably foreseeable expenses to Medicare, but fails to define what is reasonably foreseeable, so the parties must use their best judgment in evaluating this issue on a case by case basis.

Attorneys for all parties to a workers' compensation settlement need to be aware of MSA's and the consequences of ignoring the Medicare Secondary Payer Act (MPSA). Claimant's attorneys should be aware that failure to comply with the Act could result in the claimant losing his Medicare benefits and CMS can make a claim against the claimant and the claimant's attorney for any benefits

improperly paid by Medicare. Defense attorneys should be aware that the employer is equally responsible for ensuring Medicare's interests are protected at the time of a workers' compensation settlement. The reality is, despite the fact that both parties have this responsibility, the employer has deep pockets relative to the claimant and is the entity that CMS will enforce the MSPA against. As a result, defense attorneys should determine if a claimant is or will soon be Medicare eligible and begin the MSA evaluation process early on in the case. The defense attorney should also protect the employer's interests by adding language to the settlement regarding the steps taken to protect Medicare's interests and even attach the approved MSA or an outline of the details of a yet to be approved MSA as an exhibit to the settlement.

A Life Care Plan (LCP) is a similar, but distinct entity from a MSA. A LCP is a comprehensive report that establishes the goals and objectives for rehabilitation and discusses current and projected future requirements of care needed for the patient to achieve a quality existence. These plans provide a comprehensive summary of the claimant's medical history, summary of the claimant's current medical treatment, and a statement of whether the claimant has reached maximum medical improvement. They also summarize the current medical, psychosocial, educational, vocational, and daily living needs of the patient. Finally, a LCP determines the life expectancy of the claimant, outlines a cost assessment of reasonably expected future medical treatment and equipment needed for the claimant over his lifetime, and provides an itemized statement with dollar figures regarding such future treatment.

This begs the question, how is a Life Care Plan different from a Medicare Set Aside? Both LCP's and MSA's seek to determine the nature and costs of all future medical treatment that a claimant will require over the course of his lifetime. The difference between the two lies in the final objective to which these arrangements are directed. LCP's are used by attorneys to demonstrate the

future medical needs of a claimant and reduce those needs to a present value for purposes of a settlement. They are an entirely voluntary, but often very useful tool for the workers' compensation attorney. In fact, obtaining a LCP could be a prerequisite for drafting a MSA, as the LCP would provide an accurate accounting of the costs of future medical treatment for purposes of setting that money aside.

In contract, MSA's are used by attorneys to ensure that Medicare's interests are protected pursuant to the Medicare Secondary Payer Act, which allows for recovery against the claimant, the employer, and the attorneys when these parties to a workers' compensation settlement fail to respect Medicare's status as a secondary payer when the claimant is or will soon become a Medicare beneficiary. The practical effect of the MSPA has been to make the use of MSA's a requirement for workers' compensation attorneys. Thus, while the purpose of a LCP is to provide an accurate accounting of a claimant's costs of future medical treatment in order to determine the amount of a settlement, the purpose of a MSA is to provide an accurate accounting of a claimant's costs of future medical treatment in order to ensure that an appropriate amount of money will be set aside from the settlement in order to protect Medicare's status as a secondary payer.