LITIGATION LIENS

Settlement obligations, subrogation, and protecting the client recovery

A practical 60-minute attorney CLE

Indiana-focused • Federal overlays • Practice-ready workflows

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1 IDENTIFY

2 VERIFY

3 NEGOTIATE

4 DISBURSE

60-minute roadmap

0–5 min | Framework: what is a lien, claim, reimbursement right, or subrogation interest?

5–20 min | Indiana-specific rights: attorney, hospital, Medicaid, workers' compensation

20–35 min | Federal overlays: Medicare and ERISA health plans

35–48 min | Settlement, trust accounting, negotiation, releases, and file closure

48–57 min | Case studies and practical exercises

57–60 min | Key takeaways and questions

Learning objectives

Distinguish statutory liens, contractual reimbursement rights, subrogation claims, and equitable liens.

Identify common lienholders and third-party recovery interests in personal-injury and other civil litigation.

Apply key Indiana statutes and professional-conduct obligations to settlement funds and disputed interests.

Use a repeatable workflow to identify, verify, challenge, negotiate, document, and resolve claims before disbursement.

Recognize Medicare, Medicaid, ERISA, workers' compensation, and hospital-lien issues that can change settlement economics.

The vocabulary matters

Statutory lien: a right created by legislation; scope and perfection requirements come from the statute.

Contractual reimbursement: a promise to repay benefits from a recovery, often found in a plan or policy.

Subrogation: substitution to another person’s rights to pursue a responsible third party or recovery.

Equitable lien by agreement: an equitable remedy enforcing an agreement tied to identifiable funds or property.

“Lien” is often used loosely—classify the right before deciding priority, enforceability, or negotiation strategy.

Why litigation liens matter

They can reduce the client's net recovery—sometimes materially.

They can delay settlement funding, closing, or distribution.

They may expose the client, counsel, insurer, or settlement proceeds to additional claims.

They create professional-responsibility and trust-account risks when interests are disputed.

They affect case valuation: a gross settlement is not the same as a net recovery.

Practice point: calculate the likely net recovery early—not after the release is signed.

The lien lifecycle

INTAKE → identify coverage, benefits, providers, prior claims, and potential third-party interests.

INVESTIGATION → obtain plan language, payment ledgers, lien notices, and proof of perfection.

ANALYSIS → determine legal source, scope, causation, amount, priority, defenses, and deadlines.

NEGOTIATION → challenge unrelated charges, seek reductions, allocate fees/costs, and document compromise.

SETTLEMENT → reserve disputed amounts; secure releases or written payoff instructions.

DISBURSEMENT → distribute undisputed funds; preserve disputed funds; account and close.

Start at intake: ask the right questions

Is the client enrolled in Medicare, Medicaid, VA/TRICARE, or a government benefit program?

Did an employer health plan, union plan, or self-funded ERISA plan pay accident-related bills?

Has workers' compensation paid benefits or medical expenses?

Which hospitals, ambulance providers, physicians, or other providers treated the client?

Has any health insurer, auto carrier, disability carrier, or prior attorney asserted reimbursement or fee rights?

Are there bankruptcy, child-support, tax, probate, or public-benefit issues affecting the recovery?

Build a lien inventory—not a pile of letters

Record claimant / administrator / provider and contact information.

Identify the asserted legal basis: statute, plan, policy, contract, court order, or assignment.

Track date received, asserted amount, date of service, payments, and last verified balance.

Record notice, filing, perfection, response, appeal, and limitation deadlines.

Assign an owner and next action; calendar follow-ups and settlement hold points.

A spreadsheet or case-management field set is often more reliable than email folders.

Indiana attorney lien: narrow statutory tool

Indiana Code § 33-43-4-1 authorizes an attorney practicing in a court of record to hold a lien for fees on a judgment obtained for the client.

The lien is on a judgment—not a universal statutory lien on every settlement or every recovery.

Under § 33-43-4-2, the attorney must enter written notice of intent and the amount claimed on the docket or record within 60 days after judgment.

If an appeal is taken, the statute provides a separate timing rule tied to the appellate disposition or final judgment after retrial.

Do not assume the statute answers every fee dispute; examine the fee agreement, common law, procedural posture, and applicable law.

Attorney lien: practice implications

Calendar the 60-day docket-entry deadline immediately when judgment is entered.

State the amount claimed and comply with the statutory record-entry requirement.

Do not confuse a statutory judgment lien with a charging lien, retaining lien, contract claim, or fee dispute.

Address withdrawal/substitution, client notice, file transfer, and fee disputes separately.

Confirm whether the recovery is a judgment, settlement, structured payment, or other fund before relying on the statute.

Indiana hospital liens: statutory framework

Indiana Code chapter 32-33-4 creates a hospital lien for qualifying reasonable and necessary hospital charges related to the injury or illness.

The lien reaches claims and certain settlement or compromise proceeds arising from the injury.

The statute makes the hospital lien subordinate to an attorney's lien upon the claim or cause of action.

The lien is subject to statutory exclusions and reductions—including insurance benefits, contractual adjustments, write-offs, and other patient benefits.

Analyze the statute as a whole: attachment, perfection, notice, contest, validity, release, and enforcement are separate questions.

Hospital lien: perfection and notice

Under § 32-33-4-4, the hospital must file a verified statement with the county recorder where the hospital is located.

Filing must occur within 90 days after discharge or before final settlement, compromise, or resolution—whichever occurs first.

The statute also requires specified notice, including to the liable person and the patient's attorney when known or reasonably discoverable.

A lien is effective when the statutory filing and notice requirements are satisfied; it is not retroactive.

Check the actual filing, dates, county, statement contents, and proof of notice—do not rely solely on a balance letter.

Hospital lien: scope, reduction, and challenge

Charges must be reasonable and necessary and related to the care, treatment, or maintenance arising from the injury.

Contractual benefits, insurance payments, adjustments, write-offs, and other patient benefits must be credited as required by statute.

Where the settlement would leave the patient with less than 20% if covered hospital liens were paid in full, the statute requires pro rata reductions sufficient to preserve that 20% share.

A person may contest a lien or the reasonableness of charges by motion to quash or reduce in the court where the lien was perfected.

Section 32-33-4-3.5 limits collection of amounts above the patient's contractual financial obligation and bars collection before the claim is resolved.

Hospital lien: settlement risk

A perfected lien may remain enforceable if the claim is settled without obtaining a release.

Section 32-33-4-6 provides a hospital lienholder a claim for the reasonable cost of care when a liable party settles after perfection without obtaining a release.

Obtain a written payoff and release; confirm the release is authorized and covers the correct patient, incident, and account.

Do not assume a provider's willingness to accept a discounted payment automatically releases all related accounts or claims.

Confirm how the hospital will file its release and whether any recorder filing or satisfaction is needed.

Indiana Medicaid: third-party liability

Indiana Code § 12-15-8-1 provides a lien against recovery where the Office paid medical expenses for an injury or illness caused by another person and the recipient asserts a damages claim.

The lien is limited by the statute to the amount paid by the Office and the extent of the other person's liability for medical expenses.

Determine which Medicaid-paid services are related to the injury and which are outside the claim.

Request an itemized payment history; dispute unrelated services and duplicate or incorrect charges with supporting records.

Do not assume a Medicaid claim is handled like a private health-plan reimbursement clause.

Indiana Medicaid: attorney fee provision

Indiana Code § 12-15-8-8 applies to liens on recoveries under §§ 12-15-8-1 and -2—not real-property liens under chapter 8.5.

The statute provides an attorney-fee amount payable by the Office: 25% of its recovery when collected without initiating legal proceedings.

If collected by initiating legal proceedings, the statutory amount is 33⅓% of the Office's recovery.

Confirm the current administrative process and calculation with the Indiana Family and Social Services Administration / Office of Medicaid Policy and Planning.

Keep the statutory attorney-fee calculation distinct from any separate negotiation over the client's net recovery.

Workers' compensation: third-party recovery

Indiana Code § 22-3-2-13 governs claims against third persons and the employer/carrier's subrogation rights.

Where compensation has been paid or liability for compensation exists, the employer/carrier may have a lien on a third-party settlement, award, judgment, or fund.

Coordinate the tort action and compensation claim early; statutory rights can affect control, timing, and allocation of the third-party recovery.

Obtain a current itemization of indemnity, medical, and other benefits paid or payable.

Analyze statutory notice, election, reimbursement, attorney-fee, and expense-allocation provisions before finalizing settlement.

Private health insurance and subrogation

Review the policy, certificate, summary plan description, and full plan document—not just the insurer's demand letter.

Determine whether the plan is insured or self-funded; ERISA preemption and enforcement issues may differ.

Identify whether the asserted right is reimbursement, subrogation, assignment, or an equitable lien by agreement.

Check the definition of "recovery," covered expenses, priority language, attorney-fee provisions, and allocation rules.

Ask for the exact plan terms in force on the date of injury and evidence of payments tied to the claim.

ERISA: why plan language can control

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes equitable relief to enforce plan terms.

Sereboff recognizes enforcement of an equitable lien by agreement against specifically identifiable settlement funds.

US Airways, Inc. v. McCutchen holds that clear plan terms generally govern; equitable doctrines cannot override unambiguous terms.

Where the plan is silent, background equitable principles—such as common-fund allocation—may inform interpretation.

Montanile addresses the limits of equitable recovery after settlement funds have been dissipated; it is not a safe harbor to spend disputed proceeds.

ERISA: the document checklist

Full plan document and amendments effective on the injury date.

Summary Plan Description and any reimbursement / subrogation addendum.

Proof the plan is self-funded or insured; identify plan sponsor, administrator, and fiduciary.

Itemized payment ledger showing date, provider, service, amount paid, and relation to injury.

Plan language on first-dollar reimbursement, made-whole doctrine, common fund, attorney fees, costs, and allocation.

Written payoff calculation and confirmation of who has authority to compromise or release the claim.

Medicare Secondary Payer: not just a ‘lien’

Medicare may make conditional payments when a primary payer has not paid promptly, subject to later recovery.

CMS describes the government’s right as an MSP recovery claim; “Medicare lien” is common shorthand but not the most precise term.

The recovery process may involve the Benefits Coordination & Recovery Center (BCRC) and the Medicare Secondary Payer Recovery Portal (MSPRP).

Identify Medicare entitlement early—even where the client is not yet receiving benefits but may become eligible during the case.

Address Medicare recovery in settlement planning, release language, client counseling, and closing documentation.

42 U.S.C. § 1395y(b); CMS Attorney Services

Medicare: operational workflow

Report the case and establish representation / consent through the appropriate CMS process.

Review the conditional payment information and compare each claim to the injury and treatment at issue.

Dispute unrelated claims promptly with supporting records and explanations.

After settlement, provide settlement date and amount, attorney fees, and itemized procurement costs as required.

Review the final demand and payment instructions; calendar response and payment deadlines.

Retain the demand, dispute submissions, proof of payment, and closure confirmation.

CMS, Attorney Services; CMS, Conditional Payment Information

Medicare: settlement math and timing

CMS takes attorney fees and other procurement costs borne by the beneficiary into account when calculating the final demand, subject to applicable rules.

Do not assume the preliminary conditional-payment figure is the final amount due.

CMS guidance describes a 30-calendar-day response period for a Conditional Payment Notice (CPN); failure to respond can result in a demand without a proportional fee/cost reduction.

Some liability cases may qualify for demand-calculation options or a fixed-percentage option—check current CMS eligibility criteria.

Build Medicare timing into the settlement calendar; do not promise immediate net proceeds before the recovery amount is confirmed.

CMS Conditional Payment Information; 42 C.F.R. § 411.37

Other recovery interests to screen

VA and TRICARE: federal reimbursement and recovery rules may apply; identify the payer and applicable program.

Federal Employees' Compensation Act / other workers' compensation programs: separate federal statutory frameworks may control.

Auto medical-payments, UM/UIM, disability, and other first-party benefits: inspect policy language and applicable state statutes.

Child support, tax levies, bankruptcy claims, probate administration, and public-benefit eligibility can affect disbursement.

Litigation funding or medical funding contracts may create contractual repayment claims; evaluate enforceability and disclosure obligations under governing law.

Common fund: useful, but not universal

The common-fund doctrine can require a beneficiary of a recovery to contribute proportionately to the cost of obtaining it.

It may be relevant to some insurer, plan, or subrogation claims, depending on governing law and plan/policy language.

McCutchen: a clear ERISA plan term can displace equitable rules; silence about recovery costs may leave room for the common-fund doctrine.

Do not assume every lienholder must share fees or costs; identify the legal source and controlling language first.

Make the fee/cost allocation part of the written negotiation and payoff—not an afterthought.

Challenge the amount: a disciplined method

Demand an itemized ledger, payment proof, plan/policy language, and authority to assert the claim.

Match every charge to the injury, date range, body part, and treatment at issue.

Remove unrelated conditions, unrelated providers, duplicate bills, reversals, adjustments, and charges not actually paid.

Check contractual discounts, write-offs, copayments, deductibles, and statutory credits.

Request a corrected balance and written explanation for every disputed item.

Preserve the record: letters, portal submissions, spreadsheets, medical support, and settlement calculations.

Negotiate: leverage and documentation

Explain limited coverage, comparative fault, causation disputes, collectability, and the risk of litigation where relevant.

Present the net-recovery picture: gross settlement, fees, costs, client damages, and all competing claims.

Request reduction based on statutory limits, common-fund principles, plan terms, equitable considerations, or administrative discretion—as applicable.

Confirm who can bind the lienholder and whether the person negotiating has delegated authority.

Obtain a signed compromise, final payoff, release, and written instructions for payment.

Settlement statement: gross is not net

Gross settlement / judgment proceeds

Less: attorney fee under written fee agreement

Less: case costs and expenses, with client authorization and accounting

Less: confirmed statutory liens and valid reimbursement obligations

Less: disputed amounts held in trust pending resolution

Equals: net amount currently distributable to client

Never present an estimate as a final net figure while material lien balances remain unverified.

Trust accounting: disputed funds

Indiana Rule of Professional Conduct 1.15 requires client and third-party property to be held separately from the lawyer's own property.

Promptly notify clients and third persons when funds or property in which they have an interest are received.

Promptly deliver funds to the person entitled to receive them and provide a full accounting on request.

When two or more persons claim an interest, keep the disputed property separate until the dispute is resolved.

Promptly distribute all portions that are not in dispute; do not use the entire settlement as leverage for a limited dispute.

Ethics: client communication and informed decisions

Explain the nature of each asserted claim and the practical consequences of ignoring it.

Discuss the range of possible lien outcomes and the effect on the client's net recovery.

Obtain client instructions before accepting a compromise or allocating proceeds.

Do not guarantee a reduction or promise a net amount before the relevant claims are resolved.

Document the client's informed approval of the settlement statement and disbursement.

Ethics: do not turn a lien dispute into a trust violation

Do not disburse funds that are subject to a legitimate, unresolved third-party claim without analyzing the governing law and ethical duties.

Do not withhold undisputed client funds merely because a smaller portion is disputed.

Do not pay a disputed claimant simply to eliminate administrative inconvenience if the client contests the claim and no legal basis requires payment.

Escalate uncertainty to ethics counsel, firm general counsel, or the appropriate risk-management resource.

Document the legal analysis, notices, client communications, trust ledger, and ultimate resolution.

Settlement release and lien language

Define the settlement amount, parties, claims released, and allocation if appropriate.

Address lienholder payment only when authority, amount, and payment instructions are confirmed.

Do not represent that all liens are satisfied unless that is accurate and supported.

Clarify whether the client or counsel is responsible for identified obligations and what funds are being reserved.

Coordinate release language with Medicare, Medicaid, ERISA, workers' compensation, and hospital-lien resolution requirements.

Keep the settlement agreement consistent with the client-approved disbursement statement.

Case study 1: the hospital lien

Facts: Indiana bodily-injury claim settles for $75,000. Hospital asserts $42,000 for emergency and inpatient care.

Hospital’s notice was recorded 105 days after discharge. Settlement has not yet been signed.

Question 1: What statutory perfection issue should counsel investigate?

Question 2: What reductions, credits, and scope questions should be raised?

Question 3: What should counsel obtain before releasing settlement funds?

Discussion: compare the filing date to § 32-33-4-4; examine notice, itemization, insurance adjustments, and release.

Case study 2: ERISA reimbursement demand

Facts: Client receives a $100,000 settlement. A self-funded ERISA plan asserts $58,000 under a broad reimbursement clause.

Client's contingency fee is 33⅓%; the plan document contains detailed language about attorney fees and recovery costs.

Question 1: What documents are essential before negotiating?

Question 2: Can the client rely on the common-fund doctrine automatically?

Question 3: What should happen to the settlement proceeds while the claim is unresolved?

Discussion: apply plan language and McCutchen; identify and preserve any specifically identifiable disputed funds.

Case study 3: Medicare conditional payments

Facts: Medicare beneficiary settles a liability claim. The conditional payment notice includes unrelated treatment and a preliminary amount.

Counsel plans to distribute the settlement immediately and “sort out Medicare later.”

Question 1: What claims should be disputed and how?

Question 2: What settlement information and procurement costs should be reported?

Question 3: What is the risk of failing to respond to the CPN within the stated period?

Discussion: identify unrelated claims, send support to BCRC, submit settlement/procurement information, and track the final demand.

A practical 10-point settlement checklist

1. Identify every potential lien, reimbursement, subrogation, or assignment claim.
2. Obtain the governing statute, policy, plan, contract, and proof of authority.
3. Verify perfection, notice, scope, and applicable deadlines.
4. Obtain itemized payments and remove unrelated or duplicated charges.
5. Calculate the gross-to-net recovery and identify any shortfall.
6. Negotiate reductions and fee/cost allocation; memorialize in writing.
7. Confirm releases, payoff amounts, payees, and wire/check instructions.
8. Prepare a client-facing settlement statement and obtain informed approval.
9. Segregate disputed funds; distribute undisputed portions promptly.
10. Retain proof of payment, releases, trust records, and closure confirmation.

Common mistakes—and how to prevent them

Treating every reimbursement letter as a perfected lien → classify the source and verify legal prerequisites.

Relying on a balance instead of a ledger → demand itemization and proof of payment.

Assuming a client's health plan is governed by state law → investigate ERISA status and funding.

Waiting until settlement to report Medicare or Medicaid → screen at intake and calendar follow-ups.

Paying a claimant without a release → obtain written payoff and release terms.

Freezing all proceeds over one disputed amount → segregate only the disputed portion and release the rest.

Build a firmwide lien-resolution process

Standard intake questions and flags for Medicare, Medicaid, ERISA, workers' compensation, hospital, and other claims.

Centralized lien register with claimant, legal basis, amount, deadline, status, owner, and next action.

Standard request letters for plan documents, ledgers, hospital lien proof, and payoff/release terms.

Settlement hold points: no final distribution until lien review and client statement are complete.

Escalation triggers for large claims, conflicting demands, disputed priority, bankruptcy, or unclear law.

Periodic audit of closed files for missing releases, unresolved balances, or trust-account exceptions.

Key takeaways

“Lien” is a label—not a legal analysis. Identify the source, scope, perfection, and remedy.

Indiana statutes create specific rights with specific requirements; read the whole chapter.

Federal Medicare and ERISA rules can materially alter settlement timing and allocation.

Negotiate with evidence: plan terms, payment ledgers, statutory credits, and documented procurement costs.

Ethical settlement practice requires communication, accounting, segregation of disputed funds, and prompt distribution of undisputed amounts.

DISCUSSION

Questions and discussion

What lien or reimbursement issue most often delays your settlements?

Which part of your current process is most vulnerable: intake, verification, negotiation, or disbursement?

What would a consistent firmwide checklist or escalation process change?

Indiana statutes

Indiana Code § 33-43-4-1	Attorney lien on judgment	https://law.justia.com/codes/indiana/title-33/article-43/chapter-4/section-33-43-4-1/
Indiana Code § 33-43-4-2	Entry of attorney lien; 60-day docket deadline	https://law.justia.com/codes/indiana/title-33/article-43/chapter-4/section-33-43-4-2/
Indiana Code §§ 32-33-4-3 to -8	Indiana hospital lien chapter	https://law.justia.com/codes/indiana/title-32/article-33/chapter-4/
Indiana Code § 32-33-4-4	Hospital lien perfection and notice	https://law.justia.com/codes/indiana/title-32/article-33/chapter-4/section-32-33-4-4/
Indiana Code § 32-33-4-3.5	Hospital lienholder restrictions	https://law.justia.com/codes/indiana/title-32/article-33/chapter-4/section-32-33-4-3-5/
Indiana Code §§ 12-15-8-1, -8	Medicaid recovery lien and attorney fee provisions	https://law.justia.com/codes/indiana/title-12/article-15/chapter-8/
Indiana Code § 22-3-2-13	Workers' compensation third-party claims/subrogation	https://law.justia.com/codes/indiana/title-22/article-3/chapter-2/section-22-3-2-13/
Indiana Code § 27-7-5-6	Insurance policy subrogation in UM/UIM context	https://codes.findlaw.com/in/title-27-insurance/in-code-sect-27-7-5-6/

Professional conduct and federal program guidance

Indiana Rules of Professional Conduct 1.15	Safekeeping property; disputed interests	https://rules.incourts.gov/Content/prof-conduct/rule1-15/current.htm
Indiana Rules of Professional Conduct 1.5	Fees	https://rules.incourts.gov/Content/prof-conduct/rule1-5/current.htm
CMS, Attorney Services	Medicare Secondary Payer recovery for attorneys	https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services
CMS, Conditional Payment Information	Conditional payment notices, disputes, portal and response process	https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services/conditional-payment-information
CMS, Liability/No-Fault/Workers' Compensation Recovery Process	Medicare recovery process and procurement costs	https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services/downloads/liability-no-fault-and-workers-compensation-recovery-process.pdf
42 U.S.C. § 1395y(b)	Medicare Secondary Payer statute	https://www.law.cornell.edu/uscode/text/42/1395y

ERISA and Medicaid federal authorities

29 U.S.C. § 1132(a)(3)	ERISA civil enforcement	https://www.law.cornell.edu/uscode/text/29/1132
US Airways, Inc. v. McCutchen, 569 U.S. 88 (2013)	ERISA plan terms and equitable defenses/common fund	https://www.law.cornell.edu/supremecourt/text/11-1285
Montanile v. Bd. of Trs., 577 U.S. 136 (2016)	ERISA equitable lien and dissipated settlement funds	https://www.law.cornell.edu/supremecourt/text/14-723
Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006)	ERISA equitable lien by agreement	https://www.law.cornell.edu/supremecourt/text/05-260
42 U.S.C. § 1396a(a)(25)	Medicaid third-party liability framework	https://www.law.cornell.edu/uscode/text/42/1396a
42 U.S.C. § 1396p	Medicaid liens and estate recovery provisions	https://www.law.cornell.edu/uscode/text/42/1396p
Indiana Rules of Professional Conduct 1.4	Communication	https://rules.incourts.gov/Content/prof-conduct/rule1-4/current.htm
Indiana Rules of Professional Conduct 1.1	Competence	https://rules.incourts.gov/Content/prof-conduct/rule1-1/current.htm
Indiana Rules of Professional Conduct 1.16	Declining or terminating representation	https://rules.incourts.gov/Content/prof-conduct/rule1-16/current.htm

IMPORTANT

Scope, assumptions, and presenter notes

Jurisdictional focus: Indiana law, with federal Medicare, Medicaid, and ERISA overlays.

Audience: attorneys handling civil litigation, personal-injury claims, insurance disputes, and settlement administration.

Educational content only; not legal advice for a specific matter and not a substitute for reviewing current statutes, regulations, plan documents, policies, or controlling precedent.

Statutory references are current to the research date shown in this deck; confirm amendments, local practice, and agency procedures before relying on a deadline or calculation.

Suggested timing: 60 minutes including three short hypotheticals and questions. Adjust discussion time to fit the accrediting body’s format.