

Fraud & Abuse Refresher and Recent Government Enforcement Actions

**NORTH TEXAS HEALTHCARE COMPLIANCE PROFESSIONALS
ASSOCIATION**

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Ashley Johnston, J.D.
(469)320-6061

ajohnston@grayreed.com
www.grayreed.com

Joshua Weaver, J.D.
(214)394-9074

jweaver@dfwhealthlaw.com
www.dfwhealthlaw.com



Overview

- Fraud & Abuse (Stark, Anti-Kickback, False Claims)
- Enforcement
- Pending Legislation





Fraud & Abuse **(Stark, Anti-Kickback, False Claims Act)**



The "Stark" Law



Stark Law

- **Prohibition**: If a **physician**, or a member of the physician's **immediate family**, has a **financial relationship** with an **entity**, then the physician is prohibited from making a **referral** to the entity for the provision of a **designated health service** paid for by Medicare, and the entity is prohibited from billing for such service, unless an **exception** is satisfied
- **Designated Health Services**
 - Include (but are not limited to) laboratory services, radiology and certain other imaging services, inpatient/outpatient hospital services, outpatient prescription drugs, DME, prosthetics/orthotics, PT/OT, parenteral and enteral nutrients, equipment and supplies, home health, radiation therapy services and supplies



Stark Law Penalties

- **Penalties:**
 - Denial of payment
 - Civil monetary penalties of up to \$15,000 for *each* offense
 - False Claims Act prosecution, and
 - Exclusion from Medicare and Medicaid programs
- Strict liability statute = No intent requirement



Stark Law Exceptions

- Simple enough, but as is often the case, the "devil is in the details"
- Stark is all about *EXCEPTIONS*.
- If an exception under Stark is met, it is permissible for the physician to make a referral of DHS to a DHS entity with which the physician (or the physician's immediate family member) has a financial relationship



Stark Law

Common Exceptions

- Stark Law exceptions require strict compliance with every element of an exception...very little wiggle room
- Commonly used exceptions to the Stark Law involving contracts with referring physicians include:
 - Fair Market Value Compensation Exception
 - Personal Service Arrangements Exception
 - Whole Hospital Exception
 - Rental of Equipment Exception
 - Space Leases
 - Physician Recruitment
 - Employment
 - Non-Monetary Compensation



The "Anti-Kickback" Statute (State and Federal)



Anti-Kickback Statute

- **Prohibition**: It is a FELONY to knowingly and willfully offer, pay, solicit, or receive any "remuneration" in order to induce referrals of items or services reimbursable by any Federal or State health care programs.
 - Federal statute: applies to services for which payment may be made in whole or in part under a Federal health care program.
 - State statute: mirrors federal statute, but applies to all payors.



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Anti-Kickback Statute

The Penalties

- **Penalties**
 - **Criminal**
 - Fine of up to \$25,000 per violation and/or
 - Imprisonment for up to 5 years
 - **Civil**
 - Civil fines in the amount of \$50,000 per violation
 - Plus damages of not more than 3 times the total amount of remuneration offered, paid, solicited or received
 - **Exclusion From Federal/State Programs**
 - **False Claim Actions**



Anti-Kickback Statute

- Intent-Based Statute
 - If even just **One Purpose** is to induce referrals = Anti-Kickback Statute violation
 - Intent may be inferred from circumstances surrounding the arrangement
- Definition of "**Remuneration**"
 - Any type of cash
 - Provision of free items or services
 - Conferring a benefit
- Generally, no *de minimis* exception

REMUNERATION = ALMOST ANYTHING!
e.g., return on investment, compensation and cost savings



Anti-Kickback Statute

Safe Harbors

- Safe Harbor = Payment in certain instances is not considered "remuneration"
- Must meet **all** of the requirements of a particular safe harbor to qualify for safe harbor protection
- BUT - if you don't meet all requirements, the transaction is not necessarily illegal (still need *intent*)
 - Facts and Circumstances
 - Fair Market Value is Important



Anti-Kickback Statute

Safe Harbors

- Commonly used Safe Harbors to AKS involving contracts with referring physicians include:
 - Personal Services and Management Contracts Safe Harbor
 - Investment Interests Safe Harbor
 - Ambulatory Surgery
 - Space Rental Safe Harbor
 - Equipment Rental Safe Harbor
 - Employees
 - Sale of Practice



The False Claims Act ("FCA")



False Claims Act

- The False Claims Act establishes liability for any person who **KNOWINGLY** presents false or fraudulent claims to the US government for payment.
- Forms the basis of a “qui tam” action.



False Claims Act

“Knowingly”

What is Knowingly?

- The terms "knowing" and "knowingly" mean that a person:
 - has actual knowledge of the information;
 - acts in deliberate ignorance of the truth or falsity of the information; or
 - acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required



False Claims Act Penalties

- Monetary penalties of not less than \$5,500 and not more than \$11,000 per claim
- Plus damages of not more than 3 times the total amount of remuneration offered, paid, solicited or received

100 improper claims that each paid on average \$200 could result in:
Amount paid (\$20,000) x 3 = \$60,000 + Fines (100 x 11,000) =
\$1,160,000

- Exclusion From Federal/State Programs
- Allows private person to bring FCA claims (qui tam relators) and those individuals can receive between 15% and 30% of any recovery depending on the circumstances



False Claims Act Obligation

What is an Obligation?

- Established duty arising from an express or implied contractual relationship or statute or regulation to disgorge of any overpayments
- Expressly includes retention of overpayment
 - Reverse False Claim
 - Provides liability where one acts improperly – not to get money from the government, but to avoid having to pay money to the government



RECENT ENFORCEMENT CASES



Qui Tam/Enforcement Actions

- 62 healthcare qui tam actions filed from 1987 to 1992.
- In 2011 alone, there were 471.
- In 2012, there were 412.
- FCA awards 15-30% of the recovery to whistleblowers.
- Medicare Incentive Reward Program:
 - CMS can pay whistleblowers an additional 10%.
 - Proposed Rule would expand the amount to 15% up to the first \$66 million received (potential \$9.9 million recovery for whistleblower).



Qui Tam/Enforcement Actions 2013 and 2014

- 752 new *qui tam* matters filed in 2013.
- Total federal health care recoveries under the FCA exceeded \$2.5 billion in 2013 and \$2.3 billion in 2014
 - 2014 was the 5th consecutive year FCA recoveries from health care fraud exceeded \$2 billion.
- Total rewards paid to *qui tam* relators in health care cases was \$345 million in 2013.



Recent OIG Statistics

OIG Action	FY09	FY10	FY11	FY12	FY13	Total
Criminal Actions	671	647	723	778	960	3,779
Civil Actions	394	378	382	367	472	1,993
Exclusions	2,556	3,340	2,662	3,131	3,214	14,903
HHS Investigative Receivables	\$3.0 Billion	\$3.2 Billion	\$3.6 Billion	\$4.3 Billion	\$4.0 Billion	\$18.2 Billion
Non-HHS Investigative Receivables	\$1.0 Billion	\$576.9 Million	\$952.8 Million	\$1.7 Billion	\$1.03 Billion	\$5.2 Billion
Total Investigative Receivables	\$4.0 Billion	\$3.8 Billion	\$4.6 Billion	\$6.0 Billion	\$5.0 Billion	\$23.5 Billion

Statistics are for cases in which there was a settlement with or judgment for the United States, and in which the OIG's Office of Investigations was involved.



HEAT Strike Force Activity

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and DOJ to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse. Hallmarks include data-driven analyses and interagency collaboration.

Location	Criminal Actions	Indictments	Money*
Miami	622	796	\$881,561,175
Los Angeles	60	135	\$48,295,354
Detroit	111	217	\$60,515,775
Houston	56	99	\$20,529,564
New York	31	84	\$112,298,203
Baton Rouge	43	83	\$39,166,607
Tampa	30	42	\$56,056,891
Dallas	17	57	\$30,277,662
Chicago	9	53	\$4,825,501
Total	979	1,566	\$1,203,526,733

Statistics are for cases in which there was a settlement with or judgment for the United States, and in which the OIG's Office of Investigations was involved between 2009 and 2013.



Qui Tam/Enforcement Actions

- Most relators are employees (more than 75% according to most recent surveys).
- Some are employed or affiliated with competitors.
- According to the HHS' Health Care Fraud and Abuse Program Annual Report released in February 2014, for every dollar spent on health care-related fraud and abuse in the last three years, the government recovered \$8.10.



Qui Tam/Enforcement Actions

- Just in September, an Assistant US Attorney for the DOJ's Criminal Division, announced that the DOJ will be stepping up its review of False Claims Act (FCA) qui tam complaints.
- All new qui tam complaints are shared by the Civil Division with the Criminal Division as soon as the cases are filed for immediate review.
- The Criminal Division will use criminal investigative tools (e.g., search warrants, wire taps, undercover operations and confidential informants) that it will be able to contribute to FCA cases.
- "Cases involving fraud by executives at health care providers, such as hospitals, are a high priority"



Halifax

- Background: a Compliance Officer at Halifax Health Medical Center filed a Qui Tam action alleging that the Hospital gave prohibited bonuses to least 6 doctors under employment agreements. It is alleged the amount of the bonuses increased when the doctors referred more patients to the Hospital.
- A Federal Court has ruled the case can proceed even though some of the claims were submitted to Medicaid and not Medicare.
- Government has intervened in the case and the parties reached a \$85 million settlement on March 3, 2014.



Halifax (Cont' d)

- As a bonus, each oncologists would receive a portion of a total bonus pool that was equal to 15 percent of the “operating margin” of the overall medical oncology program
- “Operating margin” meant revenue minus direct expenses of the overall program, determined on a basis that included “designated health services,” as defined by the Stark Law, including prescription drugs and outpatient services not personally performed by the medical oncologists themselves.



U.S. ex rel. Drakeford v. Tuomey

- Surgeons begin development of an ASC and Tuomey Health System was concerned about losing volume.
- Hospital hires surgeons as employees
 - Part-time employment during surgical procedures; surgeons maintained office practice separately
 - Compensation to physicians: fixed salary, plus 80% of collections, plus quality incentives
 - DOJ alleged that compensation exceeded 100% of actual collections (and was up to 140% of collections)
- Hospital internal documents projected losses on all employment agreements



U.S. ex rel. Drakeford v. Tuomey

- DOJ argues that compensation is not FMV because “the hospital’s motivation in entering into these part-time agreements was to avoid losing the referrals”
 - While Stark Law is strict liability, the DOJ looked at motivation of parties
- Hospital obtained multiple valuation analyses
- During the trial, the hospital argued reliance on advice of counsel.
- Jury found Tuomey submitted a total of 21,730 Medicare claims that were illegal due to the compensation arrangements
- Result: Hospital pays \$237 million for false claims.



RECENT ENFORCEMENT ACTIONS



Enforcement Activity

Community Health Systems (February 2015)

- Community Health Systems and three affiliated New Mexico hospitals (collectively CHS) have agreed to pay the United States \$75 million to settle allegations that they violated the False Claims Act by making illegal donations to county governments which were used to fund the state share of Medicaid payments to the hospitals.
- Under the Medicaid program, the Federal government funded three times the state share.
- Additional Information:
<http://www.justice.gov/opa/pr/community-health-systems-professional-services-corporation-and-three-affiliated-new-mexico>



Enforcement Activity

South Shore Physician Hospital Organization (SSPHO) (January 2015)

- SSPHO and its member organizations, South Shore Hospital, Inc. and Physicians Organization of the South Shore, Inc. paid kickbacks in the form of cash grants to doctors who agreed to make referrals to SSPHO providers.
- From 2001 to 2010, SSPHO approved 103 separate recruitment grants to 33 different physician groups. The recruitment grant program requested that grant recipients refer patients to participating providers, which included the South Shore Hospital.
- \$1.775 million settlement
- Additional Information: <http://www.justice.gov/usao-ma/pr/south-shore-physicians-hospital-organization-pay-1775-million-alleged-kickbacks-patient>



Enforcement Activity

Nason Medical (January 2015)

- Nason Medical, out of Charleston, South Carolina, and two of its owners, Dr. Baron S. Nason and Robert T. Hamilton allegedly:
 - Submitted claims to Medicare and TRICARE for services that were provided by physician assistants, as though the services were provided by physicians. Both Medicare and TRICARE pay 85% of the physician fee schedules for services provided by mid-level providers like physician assistants;
 - Submitted claims for testing that was not medically indicated including laboratory tests and potentially harmful CT scans;
 - Submitted claims for radiological services provided by a radiology technician who did not hold a current South Carolina license; and
 - Submitted claims for Tetanus Immunoglobulin when Tetanus Toxoid was given which is considerably less expensive;
- \$1.021 million settlement
- Qui Tam
- Additional Information: <http://www.justice.gov/usao/sc/news/1.14.15.nason.html>



Enforcement Activity

Easton Hospital (December 2014)

- Easton Hospital billed Medicare for procedures which were not performed, were only partially completed, or were medically unnecessary.
- \$662,000 Settlement
- Qui Tam
- Additional Information: <http://www.justice.gov/usao-edpa/pr/easton-hospital-agrees-pay-government-662000-resolve-false-claims-act-allegations>



Enforcement Activity

Parkland Hospital (Dallas) (November 2014)

- Former employee at Parkland Hospital in Dallas pleaded guilty on 11/25/2014 to a federal felony offense stemming from his theft of patient information from the hospital.
- He faces a maximum statutory penalty of five years in federal prison and a \$250,000 fine.
- As a registration specialist at Parkland Hospital, the employee entered patient information into Parkland's computer system. Mathew used his position to obtain confidential patient information, including patients' names, telephone numbers, dates of birth, participation in the Medicare program, and government-issued health insurance claim numbers.
- Former employee used the information to market his home health business.
- Additional Information:

http://www.justice.gov/usao/txn/PressRelease/2014/NOV2014/NOV25Mathew_plea.html



Enforcement Activity

Hollywood Pavilion (November 2014)

- Former chief operating officer of a Miami-area hospital pleaded guilty for his role in a mental health care fraud scheme that resulted in the submission of more than \$67 million in fraudulent claims to Medicare by a psychiatric hospital located in Hollywood, Florida.
- HP submitted false and fraudulent claims to Medicare for treatment that was not medically necessary or not provided to patients. The COO supervised HP's staff at both its inpatient and outpatient facilities, where Medicare beneficiaries were admitted to HP regardless of whether they qualified for mental health treatment, and were often admitted before seeing a doctor.
- HP obtained Medicare beneficiaries from across the country by paying bribes and kickbacks to various patient brokers. The COO instructed the patient brokers to falsify invoices and marketing reports in an effort to hide, and cover up the true nature of the bribes and kickbacks they were receiving from HP. 4 colleagues have already been sentenced to prison terms ranging from 6-25 years for the same offenses.
- Additional Information: <http://www.justice.gov/opa/pr/miami-area-hospital-chief-operating-officer-pleads-guilty-67-million-mental-health-care-fraud>



Enforcement Activity

Shelby Regional Medical Center-Tyler, Texas (November 2014)

- Former CFO of Shelby Regional Medical Center in Center oversaw the implementation of electronic health records for the hospital and was responsible for attesting to the meaningful use of electronic health records in order to qualify to receive incentive payments under Medicare's Electronic Health Record (EHR) Incentive Program.
- On Nov. 20, 2012, White knowingly made a false statement to Medicare falsely representing that the hospital was a meaningful user of electronic health records, when the hospital did not meet the meaningful use requirements. As a result, Shelby Regional Medical Center received \$785,655.00 from Medicare.
- Faces up to 5 years in prison.
- Additional Information: <http://www.justice.gov/usao/txe/News/2014/edtx-hcf-white-111314.html>



Enforcement Activity

Riverside General Hospital -Houston, Texas (October 2014)

- Hospital President and colleagues operated a scheme to defraud Medicare beginning in 2005 and continuing until June 2012. The defendants caused the submission of false and fraudulent claims for partial hospitalization program (PHP) services to Medicare through the hospital. A PHP is a form of intensive outpatient treatment for severe mental illness.
- Specifically, evidence at trial demonstrated that the Medicare beneficiaries for whom Riverside and its satellite locations billed Medicare for PHP services did not qualify for or need PHP services. Moreover, the Medicare beneficiaries rarely saw a psychiatrist and did not receive intensive psychiatric treatment. In fact, some of the Medicare beneficiaries were suffering from Alzheimer's and could not actively participate in any treatment even if they actually qualified to receive PHP services.
- Kickbacks were paid to patient recruiters and to owners and operators of group care homes in exchange for those individuals delivering ineligible Medicare beneficiaries to the hospital's PHPs.
- Additional Information: <http://www.justice.gov/opa/pr/president-houston-hospital-and-three-others-convicted-158-million-medicare-fraud-scheme>



PENDING LEGISLATION

- Pending is emphasized – NOT THE LAW (YET)
- Committee assignments made just two weeks ago
- Just a random sample of pending legislation and possible trends



Texas Legislature – Pending Legislation

Hospitals

S.B. 424 (Relating to the licensing and regulation of hospitals)

- An applicant for the issuance of a hospital license or renewal of a hospital license must provide the DSHS with a surety bond in an amount sufficient to cover the costs associated with:
 - The storage of medical records for 10 years if the hospital is closed;
 - Any court-appointed trustee to operate the hospital.



Texas Legislature – Pending Legislation

Hospitals

S.B. 424 (Relating to the licensing and regulation of hospitals)

- The DSHS shall conduct an inspection of each licensed hospital at least once every 3 years.
- The DSHS may issue an emergency order to suspend a license if the DSHS has reasonable cause to believe that the conduct of a license holder creates an immediate danger to public health or safety.
- The emergency suspension is effective immediately without a hearing on notice to the license holder.



Texas Legislature – Pending Legislation

Hospitals

S.B. 424 (Relating to the licensing and regulation of hospitals)

- The DSHS may request the AG to bring an action in the name of the State for the appointment of a trustee to operate a hospital if (1) the hospital is operating without a license; (2) the DSHS has suspended or revoked the license; (3) license suspension or revocation procedures are pending and the DSHS determines that an imminent threat to patients exists; (4) the DSHS determines that an emergency exists that presents an immediate threat to patients; or (5) the hospital is closing and arrangements for relocation of patients to other licensed institutions have not been made before closure.



Texas Legislature – Pending Legislation

Hospitals

H.B. 1008 (Relating to the establishment of a program for the transfer of unused drugs to public hospitals)

- To the extent allowed by Federal law, the DSHS shall establish a program under which a hospital or another health care facility may transfer to the DSHS or another designated entity unused drugs that the facility received reimbursement for the cost of under the Medicaid program.
- No payment for the transfer.



Texas Legislature – Pending Legislation

Hospitals

S.B. 373 and H.B. 938 (Relating to increased oversight by the DSHS of hospitals that commit certain violations)

- If the DSHS finds that a hospital has committed a violation that resulted in a potentially preventable adverse event which is reportable under Chapter 98 of the Texas Health & Safety Code, the DSHS shall require the hospital to develop and implement a plan for approval by the DSHS to address the deficiencies that may have contributed to the preventable adverse event. The plan shall include:
 - Staff training and education;
 - Supervision requirements for certain staff;
 - Increased staffing requirements;
 - Increased reporting to the DSHS; and
 - A review and amendment of hospital policies



Texas Legislature – Pending Legislation

Hospitals

H.B. 695 (Relating to the carrying of a concealed handgun on hospital or nursing home premises)

- A private hospital or nursing home may adopt rules prohibiting a concealed handgun license holder from carrying a handgun on its premises only if:
 - The facility stations a commissioned security officer who is wearing the officer's uniform and carrying the officer's weapon in plain view at each entrance to the facility; and
 - The facility gives effective notice under Section 30.06 of the Penal Code.
- Under current Section 30.06 of Penal Code, it is an offense if the license holder: (1) carries a handgun on the property of another without effective consent; and (2) received notice that: (A) entry on the property by a license holder with a concealed handgun was forbidden; or (B) remaining on the property with a concealed handgun was forbidden and failed to depart. (b) For purposes of this section, a person receives notice if the owner of the property or someone with apparent authority to act for the owner provides notice to the person by oral or written communication.



Texas Legislature – Pending Legislation

Hospitals

S.B. 359 (Relating to the authority of a peace officer to apprehend a person for emergency detention and the authority of certain facilities to temporarily detain a person with mental illness)

- A facility may detain a person who voluntarily requested treatment or who lacks capacity to consent to treatment if:
 - The person expresses a desire to leave the facility or attempts to leave before the examination or treatment is completed and
 - A physician at the facility (1) has reason to believe and does believe that the person has mental illness and because of that mental illness there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained; and (2) believes that there is not sufficient time to file an application for emergency detention.
- The facility shall notify the person if it intends to detain the person under this section.



Texas Legislature – Pending Legislation

Hospitals

S.B. 359 (Relating to the authority of a peace officer to apprehend a person for emergency detention and the authority of certain facilities to temporarily detain a person with mental illness)

- The physician shall document a decision to detain a person in the patient's medical record. The medical record must contain (1) a statement that the physician has reason to believe and does believe that the person is mentally ill; (2) a statement that the physician has reason to believe that the person evidence a substantial risk of serious harm to self or others; (3) a specific description of the risk of harm; (4) a statement that the physician has reason to believe that the risk of harm is imminent unless the person is immediately restrained; (5) a statement that the physician's beliefs are derived from specific behavior, overt acts, attempts or threats that were observed by or reliably reported to the physician; and (6) a detailed description of the specific behavior, acts, attempts or threats.
- Period of detention may not exceed 4 hours.
- The facility shall release the patient by end of 4 hour period unless the facility arranges for a peace officer to take the person into custody.
- Facility that acts in good faith and without malice is not civilly or criminally liable.



Texas Legislature – Pending Legislation

Medicaid Expansion

H.B. 977 (Relating to expanding eligibility for medical assistance to certain persons under PPACA)

- To the extent funds are appropriated to the Commission for that purpose, the Commission shall provide medical assistance to all persons who apply for that assistance for whom federal matching funds are available under PPACA to provide that assistance.
- Does not authorize the Commission to provide medical assistance to undocumented immigrants.



Texas Legislature – Pending Legislation

Insurance Coverage

H.B. 1041 (Relating to administrative and judicial review of certain Medicaid reimbursement disputes)

- A provider has the right to a contested case hearing to dispute the amount of a reimbursement rate paid to the provider under the fee-for-service Medicaid program or by a managed care organization under the managed care Medicaid program if the provider maintains that the rate is below the rate necessary to recover the provider's reasonable operating expenses and to realize a reasonable return on the provider's investments that is sufficient to ensure confidence in the provider's continued financial integrity.
- Exhaustion of contractual remedies with a managed care organization or its agent is not a prerequisite to a contested case hearing.
- Judicial review is available, except that party seeking judicial review must file suit not later than the 45th day after the date notice of the decision made by the hearing officer was mailed.



Texas Legislature – Pending Legislation

Insurance Coverage

H.B. 694 (Relating to coverage for supplemental breast cancer screening under certain health benefit plans)

- An issuer of a health benefit plan that provides coverage for mammography, including coverage for low-dose mammography must also offer to provide coverage for supplemental breast cancer screening as part of an annual well-woman examination if the provider screening the patient for breast cancer finds that the patient has
 - Dense breast tissue;
 - Additional risk factors determined by the Health and Human Services Commissioner that warrant supplemental breast cancer screening beyond mammography.
- An additional premium may be charged for the supplemental breast cancer screening.
- Applies to health benefit plans that provide benefits for medical or surgical expenses and small employer health benefit plans.



Texas Legislature – Pending Legislation

Out-of-Network Legislation

H.B. 616 (Relating to Payment of Out-of-Network Charges)

- An insurer must use a charge-based methodology for computing a payment for a service provided by an out-of-network provider if the provider submits a clean claim that includes a certification of the usual and customary charge for the service determined by a database provider or a certification that there are not sufficient reported charges in the database provider’s database to establish the usual and customary charge.
- “Usual and customary charge” means a charge for a service, classified by geozip area (all areas with same 1st 3 digits of zip code) and CPT code, that is in the 90th percentile of the charges for that service reported to a database provider.
- “Database provider” means a nonprofit database provider certified by the TDI.



Texas Legislature – Pending Legislation

Out-of-Network Legislation

H.B. 616 (Relating to Payment of Out-of-Network Charges)

- If an OON provider submits a clean claim that includes a database certification indicating that the billed charge is not higher than the usual and customary charge, the insurer shall pay the lesser of the billed charge or the usual and customary charge minus insured's responsibility.
- If the certification indicates the charge is higher than the usual and customary charge, the insurer shall pay the billed charge if the billed charge is justifiable considering special circumstances under which the services are provided. If no special circumstances, the insurer shall pay usual and customary charge.
- If the certification indicates the database provider does not have sufficient information, insurer shall pay 80% of the billed charge or an amount equal to the 90th percentile of the charges for the service reported by the designated reimbursement information organization for providers in same geozip, whichever is less.



Texas Legislature – Pending Legislation

Out-of-Network Legislation

H.B. 574 (Relating to Operations of Managed Care Plans with Respect to Providers):

- An insurer may not terminate participation of a provider solely because the provider informs an enrollee of the full range of providers available to the enrollee, including OON providers.
- An insurer may not terminate, or threaten to terminate, an insured's participation in a plan solely because the insured uses an OON provider.
- An insurer may not prohibit, penalize, terminate or otherwise restrict a preferred provider from communicating with an insured about the availability of OON providers.
- An insurer's contract with a preferred provider may require that before an OON referral is made, the provider inform the insured that (1) the insured may choose an OON provider; (2) the insured may have a higher out-of-pocket expense with an OON provider and (3) whether the provider has a financial interest in the OON provider.



Texas Legislature – Pending Legislation

Out-of-Network Legislation

H.B. 574 (Relating to Operations of Managed Care Plans with Respect to Providers):

- On request, an insurer shall provide to a practitioner whose participation in a preferred provider benefit plan is being terminated all information on which the insurer wholly or partly based the termination, including the economic profile of the preferred provider, the standards by which the provider is measured, and the statistics underlying the profile and standards.



Texas Legislature – Pending Legislation

Freestanding Emergency Medical Care Facilities

S.B. 425 (Relating to health care information provided by and notice of facility fees charged by freestanding emergency medical care facilities):

- A FER shall post a notice that states the following:
 - That the FER is a FER and not an urgent care center;
 - Either that the FER does or does not participate in a provider network;
 - Any facility fee charged by the FER, including the minimum and maximum facility fee amounts charged per visit;
- The notice must
 - Identify the provider network and each physician at the FER who is excluded from the network;
 - State that the physician may bill separately from the FER and provide the minimum and maximum amounts the physician charges per visit.



Texas Legislature – Pending Legislation

Freestanding Emergency Medical Care Facilities

S.B. 425 (Relating to health care information provided by and notice of facility fees charged by freestanding emergency medical care facilities):

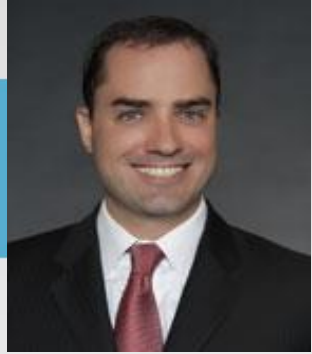
- The notice must be posted prominently and conspicuously at the FER's
 - Primary entrance
 - Each patient treatment room; and
 - At each location at which a person pays for health care services.



Discussion

- Questions?





Joshua M. Weaver
Weaver & Weaver, PLLC
(214)394-9074

jweaver@dfwhealthlaw.com
www.dfwhealthlaw.com



Ashley E. Johnston
Gray Reed & McGraw, PC
(469)320-6061

ajohnston@grayreed.com
www.grayreed.com

Josh and Ashley provide counsel to health care providers on complex operational, transactional and compliance issues. They have experience advising hospitals, ambulatory surgery centers, independent diagnostic testing facilities, laboratories, pharmacies, physicians and other health care providers on various issues, including matters implicating the Federal Anti-Kickback Statute, the Physician Self-Referral ("Stark") Statute, the Texas Illegal Remuneration Statute, The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the False Claims Act, and the Emergency Medical Treatment and Active Labor Act ("EMTALA"), among many others. Josh and Ashley also advise clients with respect to reimbursement issues and payor audits. Their transactional experience includes drafting and negotiating a variety of health care contracts, including professional services agreements, physician employment agreements, asset purchase agreements, management and co-management agreements, business associate agreements, operating agreements, and equipment and space leases, among others. Josh and Ashley also assist clients in the formation and syndication of hospitals, ASCs, joint ventures, pharmacies, and laboratories.

Josh and Ashley are both Board Certified in Health Law by the Texas Board of Legal Specialization.

