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INSIDE:

Florida Patient Rights – How Far Can you Go?

By: Maria T. Santi

In Florida, patient rights are guaranteed by statutes. How far can patients go when their rights have been violated? This article will discuss when and how violation of patient rights are actionable under Florida Law.

I. The Florida Patient Bill of Rights

Florida has codified the Florida Patient Bill of Rights and Responsibilities under section 381.026 of the Florida Statutes. The main focus is on individual dignity, including disclosure of information as to qualification of healthcare providers, informed consent, right to privacy and transparency and disclosure related to financial information. This Bill of Rights applies to hospitals, ambulatory surgical centers, medical doctors, osteopathic physicians, podiatric physicians, nurse practitioners and hospice service providers. **§381.026(2)(c), Fla. Stat.**; **§400.6095(3), Fla. Stat.** The purpose of this Bill of Rights is to increase and facilitate communication between patients and medical providers and to avoid misunderstandings. Patients are also entitled to receive itemized billing information when requested, along with an explanation of any charges. A healthcare facility or healthcare provider may not require a patient to waive his or her rights as a condition of treatment. Facilities and providers are also required to provide a summary of patient rights to their patients and inform them on how to file complaints with the facility and appropriate state agencies. However, this section cannot be used to bring any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law. Section 381.0261 of the Florida Statutes does allow the Agency for Health Care Administration (AHCA) to impose fines when healthcare providers fail to provide a summary of patient rights.

II. When Can Patients Sue for Violation of their Rights?

There are other statutory provisions in Florida which do allow actions against healthcare facilities and providers when patient rights are violated. These include substance abuse facilities, nursing homes, assisted living facilities, and mental health facilities.

A. Baker Act - Mental Health Services

Individuals and patients who receive mental health services from any service provider are guaranteed protection of their rights as specified by the Florida Mental Health Act, also known as the Baker Act, and service providers must ensure the protection of such rights. *See* §394.459, Fla. Stat. This applies to cases where individuals are treated for mental health issues, whether voluntarily or involuntarily at a mental health facility. In general, these rights are individual dignity, retention of all constitutional rights, right to treatment, right to express and informed patient consent, quality of treatment, communication, abuse reporting and visits, care and custody of personal effects, voting in public elections, right to counsel, habeas corpus and right to participate in treatment and discharge planning. Service provider personnel who violate or abuse any right or privilege of patients under this chapter are liable for damages as determined by law. There is a provision that states that persons who act in good faith in treating patients under

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this Act are free from liability, however, if there is negligence in connection with the treatment, this provision is inapplicable and patients can bring a civil action for damages. §394.459(10), Fla. Stat.

B. Substance Abuse Services

Individuals and patients who receive substance abuse services from any service provider are guaranteed protection of their rights as specified by the Marchman Act, and service providers must ensure the protection of such rights. *See* §397.501, Fla. Stat. This applies to cases where individuals are treated for substance abuse, whether voluntarily or involuntarily at a substance abuse facility. These rights include individual dignity, retention of all constitutional rights, nondiscriminatory services, right to quality services, communication, care and custody of personal effects, education of minors, confidentiality of individual records, right to counsel and habeas corpus. Service provider personnel who violate or abuse any right or privilege of an individual under this chapter are liable for damages as determined by law. Persons who act in good faith and reasonably are free from liability. If there is negligence in connection with the treatment, however, this provision is inapplicable and individuals and patients can bring a civil action for damages against substance abuse providers.

C. Nursing Home Residents

Nursing home resident rights are delineated under section 400.022 of the Florida Statutes. The list contains 22 specified rights, including the right to present grievances, to refuse medication, and to be informed of proposed treatment, among others.

Any violation of resident rights will be subject to administrative fines and penalties from AHCA. Nursing home patients and families can also bring civil actions against nursing homes for resident/patient rights violations. *See* §400.023, Fla. Stat. A cause of action for negligence or a violation of residents' rights for the personal injury or death of a resident may be brought against the licensee, the licensee's management or consulting company, the licensee's managing employees, and any direct caregivers, whether employees or contractors. A resident can also seek injunctive relief or an administrative remedy. The resident is entitled to recover the costs of the action, and reasonable attorney fees assessed against the defendant of up to $25,000.

D. Health Care Clinics and Urgent Care Centers

Health care clinics are subject to patient rights as applied to the healthcare professionals that provide services at the clinics. Aside from this standard application of patient rights, clinics must publish a schedule of charges for the medical services offered to patients. *See* §400,9935(i), Fla. Stat. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the urgent care center and must include, but is not limited to, the 50 services most frequently provided by the clinic. The failure of a clinic to publish and post a schedule of charges as required by this section results in a fine by the Agency for Health Care Administration of not more than $1,000, per day, until the schedule is published and posted. The statutory provisions related to health care clinics do not provide legal means for a civil action under section 400.9935 of the Florida Statutes.

E. Transitional Living Facilities

A transitional living facility is a site where specialized healthcare services are provided to patients who have brain or spinal cord injuries, including, but not limited to, rehabilitative services, behavior modification, community reentry training, aids for independent living, and counseling. *See* §400.9971(7), Fla. Stat. Part XI of Chapter 400 of the Florida Statutes delineates responsibilities and standards for the care of persons under these circumstances. There are no delineated patient rights or causes of action under this section, but these facilities are subject to patient rights as applied to the healthcare professionals that provide services at the facilities. The facilities can face penalties from AHCA for violations of the responsibilities and standards delineated in accordance with the nature of the violation and the gravity of its probable effect on facility clients. *See* §400.9983, Fla. Stat.

F. Privacy Rights

Privacy rights are another aspect of patient rights that affect individuals on a daily basis. In addition to federal protection under HIPAA, Florida law also gives patients a number of privacy rights. For example, a patient's medical records are confidential and must not be disclosed without the consent of the patient. §395.3025, Fla. Stat. Further, any healthcare practitioner's employer who is a records owner shall maintain records or documents as provided under the confidentiality and disclosure requirements of §456.057, Florida Statutes. Records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient, the patient's legal representative, or other healthcare practitioners and providers involved in the patient's care or treatment, except upon written authorization from the patient. Home health agencies are required to keep medical records confidential pursuant to section 400.494 of the Florida Statutes, and other general privacy protections apply to other types of entities. *See, e.g.* **§400.945, Fla. Stat.**

The Florida Information and Protection Act of 2014 ("FIPA") also protects

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patients' personal information, including medical history, mental or physical condition, medical treatment, diagnosis, health insurer numbers and certain other information. *See* **§501.171(g)1, Fla. Stat.** While there is no private cause of action under HIPAA and FIPA, causes of action for invasion of privacy and breach of confidentiality can be brought when patient information is wrongfully disclosed. However, there have to be ascertainable damages to proceed with a cause of action. There are exceptions where the breach itself justifies legal action. These exceptions are related to the release of mental health records and HIV results. As related to disclosure of HIV results, healthcare facilities and professionals have a duty to maintain HIV test results confidential pursuant to §381.004(3)(f), Fla. Stat. (2018). A breach of confidentiality under this section falls below the reasonable standard of care for handling these types of test results. The law does not require that the disclosure be intentional for a violation to occur. An entity that negligently and unlawfully violates a patient's right of confidentiality and privacy in disclosing the results of HIV testing may be held responsible in a civil negligence action for damages caused to the patient by the unlawful disclosure. *Fla. Dep't of Corr. v. Abril*, 969 So. 2d 201, 202 (Fla. 2007). Emotional distress itself is sufficient to establish damages and is not subject to the impact rule when HIV results are disclosed.

As to mental health records, any communication between any person licensed or certified as a mental health therapist and her or his patient shall be confidential. §491.0147, Fla. Stat. A fiduciary relationship exists in the psychotherapist-patient and physician-patient contexts. *Gracey v. Eaker*, 837 So. 2d 348 (Fla. 2002). A fiduciary has a duty not to disclose the confidences reposed in him by his patients. A psychotherapist who has created a fiduciary relationship with his client owes that client a duty of confidentiality and a breach of such duty is actionable in tort. Emotional distress itself is sufficient to establish damages and is not subject to the impact rule when mental health records are disclosed.

Florida law also gives patients a number of other rights, including rights relating to payment of processing of medical bills. Both providers and patients should be aware of these rights to promote compliance and facilitation of positive communication.

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Florida Supreme Court Finds that Medicaid Can Only Lien on a Tort Recovery so Much

By: Seann M. Frazier

In *Giraldo v. Agency for Health Care Administration*, 248 So. 3d 53 (Fla. 2018), the Florida Supreme Court resolved a split in authority on the question of whether the Medicaid Program may place a lien against the "future medical expenses" portion of damages paid by a tortfeasor. In *Willoughsby v. Agency for Health Care Administration*, 212 So. 3d 516 (Fla. 1d DCA 2017), the Second District Court of Appeal found that the Medicaid Program may only recover payments made to recompense *past* medical bills. However, the First District Court of Appeal reached the opposite conclusion in *Giraldo v. Agency for Health Care Administration*, 208 So. 3d 244 (Fla. 1st DCA 2016), finding that the Medicaid Program may recover payments made for both past medical bills and for the reasonably anticipated *future* medical costs. The Florida Supreme Court sided with the Second DCA, finding that the Medicaid Program may only recover payments made for past medical expenses. To reach its conclusion, the Supreme Court examined both Florida and federal law.

Section 409.910, Florida Statutes, Florida's Medicaid Third Party Liability Act ("TPL Act"), declares that the Medicaid Program is intended to be the payor of last resort for services provided to Medicaid recipients. The law declares that Medicaid is to be repaid in full from any third party benefits, including payments obtained from tortfeasors. When the Medicaid Program placed a lien against a tort recovery for an amount contemplated in the TPL Act, representatives of the recipient contested the amount of the lien because it sought payment for future medical expenses. After an administrative law judge and the Agency found that the amount of the lien was proper, the recipient's representatives appealed to the First DCA. The First DCA affirmed the Agency's decision, holding that the TPL Act allowed the Agency to collect tort payments made for past *and* future medical bills.

The Florida Supreme Court focused on federal laws governing the Medicaid Program, Title XIX of the Social Security Act. The court found that federal law placed a ceiling on the amount that states may recover from third party payments to recipients. In particular, the court found that 42 U.S.C. § 1396a(a)(25)(H) limited recovery to payments made for services "furnished" to a recipient. Noting the clear use of past tense in the federal law, the Florida Supreme Court found that the law clearly allowed for recovery of only Medicaid payments for *past* medical expenses, not future ones.

The court quashed the First DCA opinion in *Giraldo* and instead approved of the Second DCA's opinion in *Willoughsby*.

In a concurring opinion, Justice Polston indicated that he did not read the federal Medicaid Act to prohibit recovery for future medical expenses, but that the United States Supreme Court decision in *Arkansas Department of Health & Human Services v. Ahlborn,* 547 U.S. 268, 275, 126 S. Ct. 1752 (2006) compelled him to conclude that AHCA may only seek a lien for past medical expenses

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From the Editor

Getting to Know Gregory Chaires

Gregory A. Chaires is the current Chair of the Florida Bar Health Law Section. He practices in Altamonte Springs at Chaires, Brooderson & Guerrero, P.L. He has been Board Certified in health law by the Florida Bar since 2001. He has a deep background in a number of health law areas. Prior to founding the law firm where he practices, he was the General Counsel to the Boards of Nursing, Dentistry, Respiratory Care and Opticianry, and the Assistant General Counsel to the Board of Medicine. He also served as the legal advisor to the Medicaid Fraud Control Unit for the Office of the Attorney General in South Florida.

This article is part of a series of interviews highlighting members of our section. Please contact the author at shannon.hartsfield@hklaw.com to recommend someone who should be featured in an upcoming edition.

What made you decide to become a health lawyer?

I kind of fell into being a health care lawyer. I always loved medicine and the intellectual challenge of it. Shortly after joining the Department of Education as an administrative prosecutor, I presented a complicated case to the Educations Practice Commission. That day, the legal counsel happened to be the head of the Administrative Law Section at the Attorney General's Office. She asked me to submit a resume that day, and within weeks I was hired as assistant counsel to the Board of Medicine and became general counsel to a few other health care regulatory boards. I loved it and have never looked back. I went into private practice over twenty years ago and honed my skills in regulatory, administrative and transactional law in the health care space. While being a health care attorney can be challenging, it has been very fulfilling.

There are a number of bar organizations focused on health law. What made you decide to get so involved in the Florida Bar Health Law Section?

I originally got involved with the health law section many years ago because I knew a few people on the Executive Council and wanted to get involved in some bar activities. In those days, health law was in its infancy and there were not a lot of health law organizations for attorneys. I served on the Executive Council for six years and then took a break. I came back after a few years and was fortunate to be nominated and approved to serve again. That led me to becoming an officer and now the Chair of the Section. I remember getting a call from then Chair Charmaine Chui. She asked if I would be her secretary to the Section, which in the HLS has traditionally been determined by the incoming Chair. She informed me that meant I would be on a four year track to becoming Chair to the Section and I agreed. It has been a fun and educational journey. I am honored to serve this year and hope to be a meaningful Section Chair.

If you were not a lawyer, what other profession would you have chosen?

If I were not a lawyer, being a physician would certainly have been an alternative. I like to be engaged and like the practice of law, medicine keeps you engaged and involved. I enjoy interacting with people and helping them if I can. Both professions lend itself to that. In another life, being a professional musician would have been great.

What advice do you have for new lawyers just starting to practice?

For new lawyers, it is important to develop depth. By that I mean, a lawyer needs to develop substantive knowledge of whatever subject matter he or she handles. If you have no depth, you will be exposed and it can come back to bite you in many ways. Follow through is very important, and remember that you should be mindful to treat clients like you would want to be treated. Lastly, you must stay put long enough in positions and practice in the geographical (and subject matter) area that you want for your career. The law has a way of pigeon holing people if they are not careful so find that area of law you want to practice and stay the course. Over time, with the development of depth and hard work, good things will happen.

What do you see as the biggest challenge facing the Health Law Section in the next five years?

The biggest challenge for the Section is staying relevant to its members. Health law has been one of the fastest areas of growth in the legal field. It is important to have resources available that are meaningful for the Section's membership. There are lots of competing organizations in the world of health law, so the Section needs to continue to provide a quality CLE product for its members, a place to exchange ideas, develop relationships, and foster a helpful and mentoring community for practitioners. A Section member survey from 2015 was telling in that it indicated that 87% of the respondents indicated they joined the Section for practice area knowledge and 71% for professional growth. Approximately 50% of the respondents wanted access to specific section materials and business development and networking.

As a section, we are enhancing our CLE product and have terrific people in place producing Health Law Monthly Updates and this Health Law Newsletter. We are looking this year to expand some things down the road that will permit all members of the Section to join the leadership at an annual retreat, which will be a great way for people to develop relationships, find mentors and colleagues to learn from, obtain CLE and

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enjoy some of the fun things Florida has to offer with colleagues that practice in the health law arena.

If someone wants to get more involved in our Section, how would they get started?

There are multiple ways to get involved in the Section. One of the easiest is to write for this newsletter or provide case updates. People can participate either in the development of CLEs for the members, serve on steering committees, or be presenters and faculty members, including for our monthly Lunch and Learns. We have committees that can use members as the practice of law can pull people in many directions and, with more members on a given committee, that brings new energy and ideas. Certainly younger lawyers who are more technology savvy can assist the Section in being cutting edge in its use of social media platforms and other forms of communication.

Shannon B. Hartsfield *practices at Holland & Knight LLP. She is Board Certified in Health Law by the Florida Bar Board of Legal Specialization and Education.*

The Price is Not Right: Florida law on payments to Out-of-Network physicians

By: Ann M. Bittinger, The Bittinger Law Firm

As Florida providers continue to be frustrated with reimbursement rates and other administrative challenges from payers, some are asking what would happen if they simply refused to sign a new contract with a payer. What would the payers have to pay us, they ask, if we have no signed agreement?

In advising clients in this situation, Florida healthcare attorneys must grasp for straws. Other than the expansion of statutory law in 2016 regarding emergency treatment and balance billing patients, the law is not clear in Florida about what price is right for payers to pay non-contracted providers.

How is the right price determined? "What undoubtedly will result is the need for physicians to litigate what is bound to be dramatic underpayments," said Jay Epstein, chairman of legislative affairs for the Florida Society of Anesthesiologists, in 2016.[1]

The case law on this subject is not robust. Historically, as these cases progressed through Florida courts, decisions generally rested on one of two, interrelated lines of reasoning and law. The first is the common law notion of *quantum meruit*, meaning a reasonable sum of money, determined by the court, in the absence of an agreed upon price. The second notion, which in a way involves operationalization of the *quantum meruit* line, is that the insurer should pay what is "usual and customary" or "fair market value" for an insurer to pay the physician. Both lines are difficult to apply, given the disparate and non-transparent fee schedules and payment structures between physician groups and insurers.

What category of patients, services, providers and payers should be considered in evaluating what is usual and customary? Should in-network, contracted fee schedules of competitor payers and competitor providers be evaluated? Should a volume discount be considered, meaning that the contracted rate should be higher than the non-contract rate -- discounted in exchange for the patients the insurer will send to the physician? Should economic theories of supply, demand, volume and price be considered? Florida courts have yet to answer these questions.

Should the Medicare Physician Fee Schedule (MPFS) rate be considered the standard usual and customary rate? The Centers for Medicare and Medicaid Services publishes a PFS each year. Because the PFS sets the rates Medicare pays, per CPT code, for physician services provided to Medicare patients, it is an easy standard to use. But is it reflective of usual and customary rates? In the *Baycare v. AHCA* decision[2], the 2nd DCA supported rationale that produced a decision based on the MPFS.

Baycare and Health Options had a contract with a set fee schedule. Baycare terminated the contract and, post-termination, Baycare continued to treat 500 or so patients for a few months. At issue was the rates for the care of those patients during those months. The patients fell into one of three categories. First, patients' rates governed by then-Florida Statute section 641.51(8); second, patients seeking emergency services and whose rates are established by Florida Statute 641.516(5); and third, patients seeking non-emergency and non-continuing care. It is the third segment of cases – not subject to the statute – that is the issue. Baycare sent Health Options bills for the services. Health Options paid much less than the billed amounts. The court, citing *Payne v. Humana Hosp.*[3], said that the rate must be a "reasonable rate."

Baycare argued that its bills reflected the usual and customary amounts. The payer, however, wanted to define usual and customary as one hundred twenty percent of the Medicare PFS. Health Options reasoned: "it [being] well recognized in . . . medical circles that hospital billing fluctuates widely . . . and that 'hospitals' billed charges bear no resemblance to market realities.'"[4] Baycare submitted the claims to a private, third-party, voluntary dispute resolution service, which sided with Health Options and its 120% argument.

The Second District Court of Appeal upheld the dispute resolution process without opining on whether the government-imposed, non-negotiable Medicare Physician Fee Schedule is a fair measure of arm's length negotiations and fair market value in the private commercial market. Accordingly, lawyers should be careful about advising that the out-of-network rate will always be 120% of Medicare.

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In a subsequent Florida case, however, the First DCA specifically excluded Medicare rates from the consideration of what is usual and customary. This case involved an HMO product sold by two insurers and a non-par physician group that provided emergency services to HMO members.[5] Because the services were emergency services, Section 641.513(5) applied to the process for pricing the claims. That subsection mandates that payment be the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or the charge mutually agreed to by the HMO and the provider. At issue was whether the group's "charge master" billed charges were usual and customary. The group represented that self-pay patients are charged the charge master rate, although the group may accept much less than that amount to satisfy the debt.

Rather than focus on the Medicare Physician Fee Schedule, the First District Court of Appeal held that the focus must be on the "provider's charge, which means the amount billed by the provider." It said that a "usual and customary" charge could be different than the provider's billed charges. The relevant market that the court analyzed was the rates paid for the services pursuant to contracts the provider had in place for the services. The court indicated that the usual and customary physician group charges in statutes governing reimbursement by an HMO for services provided by a physician group with whom it does not have a contract is the fair market value of the services provided. The court stated that "[f]air market value is the price that a willing buyer will pay and a willing seller will accept in an arms' length transaction." The court made no distinction between whether the willing buyer and willing seller would be negotiating in or outside of a contract.

Medicare and Medicaid rates should not be included because "[t]he reimbursement rates for Medicare and Medicaid are set by the government agencies and cannot be said to be 'arm's-length'.... Thus, it is not appropriate to consider the amounts accepted by providers for patients covered by Medicare and Medicaid."[6]

This opinion did not distinguish in-network rates from other payers' non-par payments to the provider or to other providers, though. It did not address the economic theory of volume discounts: that when entering into contracts with payers, physician groups accept a lower rate in exchange for the volume of patients the insurer will send to the in-network physicians. Perhaps future Florida courts will address whether the out-of-network rate should be higher than the contracted rate, because contracted rates under economic laws already include volume discounts. In other words, perhaps the relevant reimbursement market to use as "usual and customary" is not the provider's billed charges but instead the amount that payers paid to other non-par, out-of-network physicians. These rates, under economic theory, should be higher than contracted rates due to the built-in volume discount in the contracted rates.

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Endnotes

1 Becker's Hospital CFO Report: https://www.beckershospitalreview.com/finance/florida-governor-signs-law-limiting-balance-billing-5-things-to-know.html

2 Baycare Health Sys. v. Agency for Health Care Admin., 940 So.2d 563, 565 (Fla. App. 2 Dist. 2006).

3 661 So.2d 1239, 1241, Fla 1st DCA (1995).

4 *Id.*

5 Baker County Medical Services Inc. v. Aetna Health Management LLC, 31 So.3d 842 (Fla. App. 1 Dist. 2010).

6 Id.

Will Florida Become a Completely Uncapped State for Medical Malpractice Actions?

By: Stephen P. Smith, Esq.

On June 28, 2018, Eleventh Circuit Court Judge Jose M. Rodriguez in Miami issued an order declaring the $350,000 cap per claimant on non-economic damages awards in medical malpractice actions set forth in Section 766.209, *Florida Statutes*, unconstitutional and unfair to injured plaintiffs in a case in which the defendant physician and his practice group had offered to admit liability and engage in binding pre-suit arbitration solely on the issue of damages during pre-suit. This offer was rejected by the plaintiffs and the case later went to trial, resulting in a judgment for the plaintiff and her husband. The decision has many medical malpractice lawyers thinking that the non-economic damages caps in Section 766.209 may be the next to fall after two recent Florida Supreme Court decisions in the past four years holding the non-economic damages caps in (i) medical malpractice wrongful death cases and (ii) medical malpractice personal injury actions unconstitutional on equal protection grounds. Although this decision is not yet ripe by consideration for the Florida Supreme Court, it likely is simply a matter of time before the Third District Court of Appeals renders a decision and this issue potentially makes its way back to Florida's Supreme Court to consider the constitutionality of Section 766.209's statutory caps on non-economic damages in circumstances where the plaintiff rejected an offer to arbitrate a medical malpractice claim made in pre-suit.

Judge Rodriguez's Decision Finding the Section 766.209 Caps Unconstitutional

In the underlying case, *DeFranko v. Poole*, Eleventh Judicial Circuit Case No. 16-16511-CA-15, a jury awarded a total of $500,000 in non-economic damages to a patient and her husband ($450,000 for the patient and $50,000 to her husband) against a physician and his practice group for medical malpractice in a case involving a failed cataract surgery that resulted in a plaintiff suffering blurred vision, chronic dry eyes, headaches and post-surgical pain. The defendants

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moved to reduce the award to $350,000 on the grounds that their previous offers to arbitrate had been rejected, contending the Section 766.209 arbitration caps should be applied.[1]

In his order, *Order Denying Defendants' Motion to Enter/Amend Judgment in Accordance with Sections 766.207 & 766.209, Florida Statutes,* Doc. No. 76 (June 28, 2018), Judge Rodriguez held that the non-economic damages caps imposed by Sections 766.207[2] and 766.209 violated the *DeFranko* plaintiffs' constitutional rights to equal protection on the basis of what he called "doctrinal developments" since the *University of Miami v. Echarte* decision, 618 So.2d 189 (Fla. 1993), in which the Florida Supreme Court held that the Section 766.207 and 766.209 damage caps were constitutional. *Id. at* *2-*3. In doing so, Judge Rodriguez cited the recent Florida Supreme Court decisions *Estate of McCall v. United States*. So. 23d 894 (Fla. 2014) and *N. Broward Hosp. Dist. v. Kalitan,* 219 So.3d 49 (Fla. 2017), in which the Supreme Court held that Section 766.118's caps for non-economic damages were unconstitutional in medical malpractice wrongful death cases and medical malpractice personal injury cases, respectively. Based on the *Kalitan* and *McCall* decisions, Judge Rodriguez further reasoned that he believed the state's highest court would reach a different conclusion if asked to address the issues it faced in the *Echarte* decision today, writing: "It is thus unclear how *Echarte* remains binding precedent on the issue of equal protection. *Echarte*, after all, was fundamentally premised upon the existence of a medical malpractice insurance crisis, which in *McCall* and *Kalitan*, the Florida Supreme Court found had subsided." *Id.* at *7. Judge Rodriguez thus denied the defendant physician's motion to reduce the jury's non-economic damages award.

When Will the Issue Make it to the Third District Court of Appeal and When Will This Issue Eventually Make it to the Florida Supreme Court?

Procedurally, the *DeFranko* case is now officially on appeal to the Third District Court of Appeal after Judge Rodriguez denied the defendants' motion to vacate the judgment and a Notice of Appeal was officially filed in late August of 2018. However, given the Second District Court of Appeal's decision to the contrary in *Parham v. Florida Sciences Ctr., Inc., 3*5 So.3d 920 (Fla. 2d DCA 2010) (upholding the $350,000 damages cap under Section 766.209), the issue likely eventually will be heard by the Florida Supreme Court given there could very well be conflict among District Courts of Appeal on the constitutionality of the non-economic damages caps contained in Section 766.209 if the Third District Court of Appeal upholds Judge Rodriguez's decision.[3] Regardless of whether Judge Rodriguez's decision eventually is overturned by the Third District Court of Appeal or not, however, more and more trial courts are finding Section 766.209's limitation on non-economic damages to be unconstitutional and this issue will no doubt present itself in the future. The trial court did so in the *Parham* decision, and more trial courts are likely to do the same in the future.

What Will The Florida Supreme Court Do?

Given the Florida Supreme Court's current composition, which is essentially unchanged since 2017's *Kalitan* decision striking down the non-economic damages caps in medical malpractice personal injury actions and the 2014 decision in *McCall* holding the statutory damages caps in medical malpractice wrongful death cases unconstitutional, it is difficult to see how Judge Rodriguez would be perceived as wrong in finding that *Echarte* essentially has been overruled by *Kalitan* and *McCall* if the issue eventually makes it to the Florida Supreme Court. Doing so would require it to overrule the *Echarte* decision completely, so it is unclear if the current Florida Supreme Court is willing to take that step. However, given that the Court has dispensed with the other caps in Chapter 766, the Florida Supreme Court may well conclude it is time to get rid of the caps entirely on constitutional grounds, which would leave Florida an entirely uncapped state for purposes of medical malpractice personal injury and wrongful death actions.

Stephen Paul Smith *is an associate at Marlow, Adler, Abrams, Newman & Lewis in Coral Gables, Florida. He is a graduate of the University of Notre Dame and Vanderbilt University Law School and previously served as a law clerk to the Honorable Gary R. Jones, United States Magistrate Judge, in the Northern District of Florida.*

Endnotes

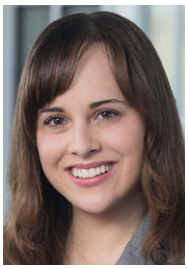
1 This would have reduced the non-economic damages award to $400,000, not $350,000, as the $350,000 cap is *per claimant* and only the patient/wife received in excess of Section 766.209's $350,000 cap.

2 Section 766.207, Florida Statutes, imposes a cap of $250,000 per claimant in instances where a prospective defendant makes an offer to arbitrate in a pre-suit medical malpractice claim that is accepted by the claimant.

3 It is interesting to note that the Third District Court of Appeal had previously considered the constitutionality of Section 766.209's damages caps and had concluded they were constitutional in a *per curiam* opinion which cited *Echarte*. Judge Rodriguez even cited this decision in his order. *See Alvarez v. Lifemark Hosps. of Florida*, 208 So.3rd 221 (Fla. 3d DCA 2016).

Did You Know? Increased Limits on Gifts to Medicare & Medicaid Beneficiaries

By: Jamie Klapholz



In 1996, when Congress added financial inducement of Medicare and Medicaid beneficiaries ("Beneficiary Inducement") to the list of offenses warranting assessment of civil monetary penalties ("CMPs"),[1] it explicitly stated that the intent was *not* to "preclude the provision of items and services of nominal value, including, for example, refreshments, medical literature, complimentary local transportation services, or participation in free health fairs."[2] A few years later, the OIG finalized rulemaking to implement this legislation, carving out several exceptions and establishing "nominal value" thresholds for permissible non-cash gifting.[3]

These thresholds were initially set at a retail value of "no more than $10 per item, or $50 in the aggregate on an annual basis."[4] But as of December 7, 2016, the maximum gift thresholds were increased, based on inflation, to $15 per item or $75 in the aggregate annually per beneficiary.[5]

Before relying on this change to justify higher value gifting, providers should carefully consider whether the contemplated gift would be characterized as a single "item" for purposes of meeting the "per item" threshold. The meaning of "per item" has not been definitively established in the Beneficiary Inducement context, but the OIG's Advisory Opinions contain a few instructive clues. See OIG Advisory Opinion No. 02-14 (HHS Oct. 7, 2002) (characterizing the monthly fee for pager service as a single "item"); see also OIG Advisory Opinion No. 12-13 (HHS Oct. 5, 2012) (characterizing a free hearing exam comprised of four diagnostic procedures as one "item").

Finally, it is important to remember that "nominal value" gifts to beneficiaries are not protected under the Anti-Kickback Statute.[6] While gifts that fit within an Anti-Kickback Statute safe harbor are insulated from Beneficiary Inducement liability,[7] there is no reciprocal protection for gifts that fall within the "nominal value" threshold or otherwise satisfy a Beneficiary Inducement exception. In other words, a "nominal value" gift given with criminal intent may still amount to a kickback.[8]

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Endnotes

1 See 42 U.S.C. § 1320a-7a(a)(5) (imposing CMPs on anyone who offers or pays a Medicare or Medicaid beneficiary remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services).

2 Joint Explanatory Statement of the Committee of Conference, H.R. Conf. Rep. No. 104-736 at 255 (1996).

3 Health Care Programs: Fraud and Abuse; Revised OIG Civil Money Penalties Resulting From Public Law 104-191, 65 Fed. Reg. 24400-01, *24411 (HHS Apr. 26, 2000).

4 Id.

5 Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 81 Fed. Reg. 88368-01, *88394 (HHS Dec. 7, 2016).

6 42 U.S.C. §1320a-7b (making it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal healthcare program).

7 42 U.S.C. § 1320a-7a(i)(6)(B).

8 See OIG Advisory Opinion No. 16-10, p. 7 n.1 (HHS Oct. 11, 2016).

Navigating the Five Levels of Appeal in Medicare Parts A and B Claims

By: Dennis Meyers, Esq.

The appeal of Medicare Parts A and B (Original Medicare) claims consists of five levels of appeal,[1] each level of appeal containing unique timelines and requirements, and in some cases, multiple timelines that run concurrently. Navigating through each of these levels of appeal, which, at the lower levels are primarily handled by CMS contractors, can be fraught with hazards, and if not done properly, could cost you that appeal.

The Social Security Act (the Act) established the five levels of appeal for Original Medicare: Redetermination (Level 1); Reconsideration (Level 2); Hearing before an Administrative Law Judge or ALJ (Level 3); Review by the Medicare Appeals Council (Level 4); and Judicial Review in U.S. District Court (Level 5).[2] The following is a brief examination of each Level.

Level 1 – Redetermination. The 1st level of appeal is a written Request for Redetermination with a Medicare Administrative Contractor (MAC), which must be filed within 120 days from receipt of the Remittance Advice (RA) which lists the initial determination. While you have 120 days to file a Request for Redetermination, it is important to note a Demand Letter will be sent after the decision or determination that there was an overpayment, and that (1) unless paid in full, interest will begin to accrue on the Amount in Controversy (AIC) on the 31st day from the date of the Demand Letter; and (2) unless an appeal is received by the 30th day from the date of the Demand Letter, CMS will begin *recouping* for that debt on the 41st day from the date of the Demand Letter. It's essential to remember that the timelines for appeal, interest and recoupment all run concurrently. Due to certain statutory limitations,[3] recoupment will stop once they receive a valid Request for Redetermination.[4] However, interest will continue to accrue on the unpaid AIC.

Level 2 – Reconsideration. A written appeal of a Redetermination decision must be filed within 180 days from receipt of the RA to appeal to the 2nd level, which is a written Request for Reconsideration to a Qualified Independent Contractor (QIC), who is tasked to conduct an independent review of the claim. Even though you have 180 days to appeal to the QIC, interest will continue to accrue on that debt, and recoupment by CMS will begin on the 61st day after the Demand Letter. Again, these timelines run concurrently, however, recoupment will stop once they receive a valid written Request for Reconsideration to the QIC.

Level 3 – ALJ Hearing. An appeal to ALJ at the Department of Health & Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS,[5] is the 3rd level of appeal, whereupon the ALJ will conduct a *de novo* review of the claim, and the legal standard of proof is by a preponderance of the evidence. A Request for ALJ must be filed on the proper CMS form (OMHA-102) within 60 days of receipt of the Reconsideration decision letter, and the claim must meet the minimum AIC.[6] However, while interest will continue to accrue on that unpaid debt, unlike in the previous lower levels of appeal, regardless of whether or not you appeal to OMHA for an ALJ Hearing, CMS will begin or resume their recoupment efforts on the 30th calendar day after the date of the QIC Reconsideration decision until the unpaid debt is satisfied or paid in full.

Level 4 – Medicare Appeals Council Review. Appeals of ALJ decisions are reviewed by the Medicare Appeals Council (Council), which are within the HHS Departmental Appeals Board (DAB) and is the 4th level of appeal. The Council is also the final administrative review of Original Medicare claims. Within 60 days of receipt of an ALJ decision you must file your request for Council review on Form DAB-101. Once they receive a request to review an ALJ decision, the Council will generally issue a decision within 90 days. However, if their review comes from an escalated appeal, then they have 180 days from receipt of the request for escalation to issue a decision. If the Council does not make a decision within the given timeframes, then a request can be made to the Council to escalate the case for judicial review in U.S. District Court.

Level 5 – Judicial Review in U.S. District Court. Whether you are appealing a decision by the Council (the written request for judicial review must be filed within 60 days from receipt of the Council's decision) or requesting judicial review because it was not heard by the Council within the given timeframe, the 5th level of appeal is for judicial review in U.S. District Court. There is a higher minimum AIC, which in 2018 is $1,600.[7] However, claims may be combined to meet that dollar amount. The Council's decision, or if no decision, the notice of right to escalation, provides instructions on filing a complaint in federal district court.

Finally, it is also worth noting that there is currently a significant backlog of appeals pending at the ALJ level, and so it may take several years before your appeal can be heard by an ALJ (the Council is also experiencing a considerable backlog), which can increase the amount of interest accruing on the unpaid AIC while navigating through these levels of appeal.[8]

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Endnotes

1 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf

2 https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Flowchart-FFS-Appeals-Process.pdf

3 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf; s*ee also* Section 1893(f)(2)(A) of the Act, and Code of Federal Regulations (CFR) at 42 CFR 405.379.

4 While there are timelines for *recoupment* of an overpayment, that is different from the *collection* of that debt, which CMS has the ability to do under certain circumstances by forwarding the debt to U.S. Treasury for collection. *See* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09-TextOnly.pdf

5 https://www.hhs.gov/about/agencies/omha/index.html

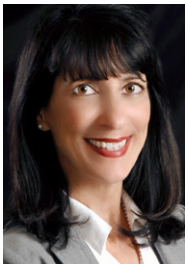
6 https://www.gpo.gov/fdsys/pkg/FR-2017-09-29/pdf/2017-20883.pdf

7 https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html

8 https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf

Opting Out of Medicare

By: Susan L. St. John



Physicians and practitioners enrolled in Medicare are ordinarily required to submit claims on behalf of Medicare beneficiaries when payment may be made for items and services provided by the physician or practitioner. However, in today's healthcare environment, more and more physicians and practitioners are considering opting out of Medicare. The following discussion is based on the Medicare Benefit Policy Manual, Chapter 15, Section 40, Effect of Beneficiary Agreements Not to Use Medicare Coverage. See also Section 1802 et seq of the Social Security Act.

For purposes of opting out of Medicare, the term "physician" is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or medicine; podiatrists; and optometrists. All must be licensed by the state in which they practice (this could be multiple states). The term "practitioner," for opt-out purposes, is limited to PAs, ARNPs, clinical nurse specialists, CRNAs, certified nurse midwives, clinical psychologists, clinical social workers, registered dietitians and nutrition professionals. Chiropractors, physical therapists and occupational therapists in independent practice may not opt out of Medicare. For ease of discussion, physicians and practitioners who may opt out of Medicare will be referred to as an "eligible" physician or practitioner.

If an eligible physician or practitioner is enrolled in Medicare, but is not participating, the physician or practitioner may opt out at any time provided that the opt out affidavit is filed with the appropriate Medicare Administrative Contractor ("MAC") within 10 days of signing his or her first private contract. If the physician or practitioner is enrolled in Medicare and is participating, he or she must submit an opt out affidavit at least 30 days before the first day of the next calendar quarter. An eligible physician or practitioner must timely submit an opt out affidavit prior to treating Medicare beneficiaries under private contract. Services may not be provided under private contract until the first day of the effective date of the opt out. The opt out period is effective for two years and automatically renews unless the automatic renewal is cancelled 30 days prior to the start of the next renewal date. An opt out may be terminated early by a physician or practitioner within 90 days of his or her first opt out period. Subsequent opt out periods may not be terminated early. Part B participation ends on the effective date of the opt out affidavit.

Opting out is "all the way out." The opt out affidavit must provide that the physician will not receive any payment from Medicare, either directly or indirectly, for covered services rendered to Medicare beneficiaries. Understanding direct payment from Medicare is easy – the physician or practitioner submits a claim and Medicare, or Medicare Advantage pays the physician or practitioner. Under opt out, the physician or practitioner may not submit claims and no one else may submit a claim to Medicare or a Medicare Advantage Plan on behalf of the opted-out physician or practitioner, not even the beneficiary.

So, what does "indirect" payment mean? Indirect payment might be in the form of salary or profit share as a partner or owner. The opted out physician or practitioner cannot receive indirect payment from Medicare by virtue of being an employee, a partner in an organization (or member or owner), or under reassignment of benefits. If the opted out physician or practitioner is part of a group practice or has assigned his rights to Medicare payment to any entity, the group practice or entity may not bill Medicare or receive payments from Medicare (or Medicare Advantage) for services provided by the opted out physician or practitioner. The practice or entity may bill and collect from a Medicare beneficiary that is under private contract with the opted out physician or practitioner.

What if the opted out physician or practitioner is a partner or co-owner of a group practice or entity that provides services to Medicare beneficiaries and bills the Medicare program? As a partner or co-owner, overall profit, derived from patient revenues including Medicare payments, would allocate over to the partner or co-owner. This would also be an "indirect" payment. Does that mean the opted out physician or practitioner must divest the ownership interest? Perhaps; unless the opted out physician's or practitioner's share in revenue was adjusted to carve out all payments received from Medicare for services and items provided to Medicare beneficiaries by the group or entity.

An opted out physician or practitioner must have a written, signed private contract with each Medicare beneficiary treated by the opted out physician or practitioner prior to rendering treatment to a Medicare beneficiary. The beneficiary will need to have a clear understanding that Medicare will not be billed and will not make any payment on behalf of items and services provided by an opted out physician or practitioner. Further, the Medicare beneficiary will need to be aware that an opted out physician or practitioner is not limited in the amount he or she may charge for items or services. Additionally, a new private contract will need to be entered into for each two-year opt out period.

Keep in mind that agreements with Medicare beneficiaries that are not authorized under Medicare and purport to waive the claims filing or charge limitations requirements, or other Medicare requirements, have no legal force and effect. A physician or practitioner who has not opted out of Medicare may be subject to civil monetary penalties pursuant to Section 1848(g)(1) or (g)(3) of the Social Security Act if he or she fails to submit a claim to Medicare on behalf of a beneficiary for covered Part B services within one year of providing such services, or charges the beneficiary in excess of the charge limitations on a repeated basis. The requirements to bill for services or to properly opt out of Medicare and enter into private contracts were enacted to protect Medicare Part B beneficiaries.

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