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Texas Civil Practice and Remedies Code Chapter 146: Defeating Hospital Liens and Charges When the Injured Party Has Health Insurance, Medicare, Medicaid or TRICARE

By S. Clark Harmonson

As a personal injury trial lawyer, one of my most regular (and least favorite) activities is dealing with a hospital after we have reached, or in order to reach, a settlement of a claim against the at fault driver and his or her insurance company. Hospitals regularly file hospital liens[1] attempting to recover the entire bill from the client out of the client's personal injury settlement. These hospital bills are frequently close to or exceed the automobile insurance policy limits of the at fault driver. Hospitals aggressively seek to recover from our clients and from the third-party automobile insurance instead of recovering from our client's own health insurance. They do so because health insurance companies won't pay the hospital's entire bill. Rather, a health insurance company is able to negotiate deep discounts of the hospital's charges. It is for that reason that hospitals would rather press their luck and try to get a larger amount from the at fault driver's automobile insurance company.

This is a major problem for injury lawyers and their clients. Our goal as personal injury lawyers is to get as much money in our client's pocket as possible. When the bean counters at the hospital stick out their grubby little fingers for all or most of the settlement, we have to dig in and fight to get the best deal possible for our client. Chapter 146 of the Texas Civil Practice and Remedies Code (CPRC) is an often overlooked but useful tool in the trial lawyer's toolbox that can be used effectively to thwart the hospital's bill where the client has health insurance or government benefits like Medicaid, Medicare, or TRICARE.

I love the title of CPRC 146: "CERTAIN CLAIMS BY HEALTH CARE SERVICE PROVIDERS BARRED." That has a nice ring to it as our goal is to pay the hospital as little as possible on behalf of our injured client. We will discuss the mechanics in more details below, but the purpose of Chapter 146 is to require health care service providers, like hospitals, to timely bill a patient's health insurance company for services rendered. When a health care service provider fails to

[1] Here is a link to an article on hospital liens that we recently wrote, Hospital Liens: https://www.clarkharmonsonattorney.com/blog/2018/march/hospital-liens-i-received-a-hospital-lien-in-the/

timely bill the patient's health insurance company, then the health care provider may not recover from the patient any amount except for an amount equal to the patient's co-insurance or deductible. In other words, a good trial lawyer can slash tens of thousands of dollars off a hospital bill when the hospital refuses to timely bill a client's health insurance utilizing Chapter 146.

Civil Practice & Remedies Code Chapter 146

Let's review Texas Civil Practice & Remedies Code Chapter 146 in depth.

CPRC Section 146.001 is the definitional section of Chapter 146. Per Sec. 146.001. "In this chapter: (1) 'Health benefit plan' means a plan or arrangement under which medical or surgical expenses are paid for or reimbursed or health care services are arranged for or provided." The term includes the following:

- Health insurance policies, whether individual, group, blanket or franchise;
- Coverage issued by a health maintenance organization (HMO) or an approved nonprofit health corporation;
- employee benefit plans;
- workers' compensation insurance policy; and
- personal injury protection (PIP) or medical payments (Med Pay) coverage from an automobile insurance policy.

Hence, almost any imaginable type of insurance policy or arrangement falls under the protection of Chapter 146 and the hospital is required to bill that insurance or face the consequences set forth in Chapter 146.

According to CPRC 146.001(2), "Health care service provider" means a person who, under a license or other grant of authority issued by this state, provides health care services the costs of which may be paid for or reimbursed under a health benefit plan." Therefore, any and all health care providers who accept insurance fall under the gambit of Chapter 146. Hospitals, urgent care centers, stand alone emergency departments (which have skyrocketed in popularity and are aggressive billers), clinics, doctors, and all other health care providers that accept insurance in Texas are subject to Chapter 146.

Timely Billing Requirement

The timely billing requirement is found in CPRC 146.002. 146.002 (a) and (b) provide as follows:

> (a) Except as provided by Subsection (b) or (c), a health care service provider shall bill a patient or other responsible person for services provided to the patient not later than the first day of the 11th month after the date the services are provided.
>
> (b) If the health care service provider is required or authorized to directly bill the issuer of a health benefit plan for services provided to a patient, the health care service provider shall bill the issuer of the plan not later than:

> (1) the date required under any contract between the health care service provider and the issuer of the health benefit plan; or
>
> (2) if there is no contract between the health care service provider and the issuer of the health benefit plan, the first day of the 11th month after the date the services are provided.

A health care provider (the hospital) must bill the patient's health insurance in accordance with the time limits set forth in 146.002(b). Generally, that is going to be not later than the first day after the 11th month after the date of service. The date may be shorter per the contract between the health insurance company and the provider. The contract between the health insurance company and the hospital could be sought in discovery if litigation is needed to enforce rights under Chapter 146.

CPRC 146.002 (c) applies where the patient has Medicaid or Medicare and provides:

> (c) If the health care service provider is required or authorized to directly bill a third party payor operating under federal or state law, including Medicare and the state Medicaid program, the health care service provider shall bill the third party payor not later than:
>
> (1) the date required under any contract between the health care service provider and the third party payor or the date required by federal regulation or state rule, as applicable; or
>
> (2) if there is no contract between the health care service provider and the third party payor and there is no applicable federal regulation or state rule, the first day of the 11th month after the date the services are provided.

According to Chapter 146, the same limits apply requiring the hospital to timely bill Medicare and Medicaid. However, there are special considerations where the client has Medicare. We will discuss claims involving Medicare below. We will also examine the application of Chapter 146 when the client has Medicaid or Tricare as well.

Claims Barred Where Insurance Not Billed Timely

CPRC 146.003 provides the penalty where the hospital fails to timely bill the client's health insurer and provides:

> Sec. 146.003. CERTAIN CLAIMS BARRED. (a) A health care service provider who violates Section 146.002 may not recover from the patient any amount that the patient would have been entitled to receive as payment or reimbursement under a health benefit plan or that the patient would not

> otherwise have been obligated to pay had the provider complied with Section 146.002.
>
> (b) If recovery from a patient is barred under this section, the health care service provider may not recover from any other individual who, because of a family or other personal relationship with the patient, would otherwise be responsible for the debt.

Hence, when the hospital doesn't timely bill health insurance, the penalty of 146.003 provides that the hospital may not recover any amount that the patient would have been entitled to receive as payment or reimbursement under the health insurance or that the patient would not otherwise have been obligated to pay had the provider complied with the timely billing requirements of 146.002. No more exorbitant hospital bill for the hospital. The hospital is reduced to recovering the client's deductible or co-insurance which essentially destroys or greatly reduces the hospital bill or lien.

Example of CPRC 146 in action

Let's give an example of how Chapter 146 can work to a client's benefit where the client has private health insurance. The client is injured in an automobile accident and goes to a local hospital after the wreck. The client works for the local school district and has Aetna health insurance. At the hospital, the clerk tells her that they won't accept the client's Aetna and instead will seek a recovery from the at fault driver's insurance. The client undergoes a CT of the head and several other diagnostic imaging studies at the hospital in order to ensure no major injuries. Thankfully for the client, she does not have major brain or other trauma and is released from the hospital on the same day. Several weeks later, the client gets a bill from the hospital for $86,069 (this is an actual bill a client of ours received for a few hour visit at the hospital). The hospital files a hospital lien for $86,069 and sends it to the automobile insurance adjuster and our firm. The hospital never bills Aetna for the charge. It is assumed that Aetna would have paid a few thousand dollars for the hospital visit.

A year goes by and the at fault driver's insurance offers to pay the client the entire policy limits of $30,000. Because that is all of the insurance money available, the offer is accepted on behalf of the client. Now, we are left with the problem of a $30,000 car accident settlement and an $86,069 hospital bill with which to contend.

We know that the hospital has violated Chapter 146 of the Civil Practice and Remedies Code. The hospital was required to bill Aetna within the first day of the 11th month after the date the services were provided. The lawyer files a lawsuit known as a declaratory judgment against the hospital on behalf of the client. Because the hospital violated Chapter 146, the judge declares that the only amount that the hospital is entitled to receive is $500, the health insurance deductible that the client was supposed to pay for going to the emergency room in the first place. The client just saved $29,500 (because the hospital wanted the entire $30,000 settlement).

Application of Chapter 146 and Medicare

Medicare is a program of the federal government that provides health insurance to people 65 and over, or under 65 and receiving Social Security Disability Insurance (SSDI), or under 65 and with End-Stage Renal Disease. The Centers for Medicare & Medicaid Services (CMS) is the agency that oversees Medicare. Medicare is funded by Social Security and Medicare taxes you pay on your income, and by Medicare premiums that Medicare beneficiaries pay, and by the federal government.

Hospitals generally do not want to bill Medicare in situations where an automobile insurance policy might cover the bill. This is because Medicare pays only 25-35 percent of the hospital's full rates. *See* Caroline Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49-APR HOUS LAW. 24, 25 (2012). A hospital would rather bill the automobile insurance and charge and recover the entire bill if possible.

Medicare is a "secondary payer" in certain cases when a Medicare beneficiary is covered by other insurance. Medicare's secondary payer provisions were designed to achieve major fiscal savings in the Medicare program. By enacting the secondary payer system, Congress reversed the policy then in effect that established Medicare as the "primary payer" in cases in which a beneficiary's need for services is related to injuries sustained in an automobile accident which could be paid for under the terms of an automobile insurance policy.

The relevant "secondary payer" statute, 42 U.S.C. § 1395y(b)(2)(A), provides in pertinent part:

> Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that- .... (ii) payment has been made or **can reasonably be expected to be made promptly** (as determined in accordance with regulations) under a . . . liability insurance policy or plan….

(emphasis added).

Hence, this statute expressly prohibits Medicare from paying if a liability carrier (automobile insurance company) has already paid or is reasonably expected to pay "promptly." According to the regulations adopted by the Health Care Financing Administration (HCFA), "promptly" is defined as within 120 days of the earlier of the date a lien is filed against a potential liability settlement or the date of discharge. Thus, Medicare is prohibited from paying during the 120-day "promptly" period pursuant to Medicare regulations. For our purposes, if the automobile insurance company pays the patient/client during the 120 day "promptly period", a hospital or other health care service provider can, through lien or otherwise, seek to recover the entire bill from the patient/client. If you represent a Medicare beneficiary in a car accident claim and the hospital has filed a lien or otherwise seeks to recover from the automobile insurance company, it is my advice not to settle the third party claim with the insurance company during the first 120 day period after discharge.

If a hospital is precluded from billing Medicare during the first 120 day "promptly period", what are the rules after the 120 day period? We are going to get into the "regulatory weeds" in order to help our client get the best deal possible.

42 C.F.R. 424.44 sets the time limits within which a health care provider must submit a claim for payment to Medicare. Subject to certain exceptions not applicable here, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending one calendar year after the date of service. 42 C.F.R. 424.44(a)(1). Further, according to the secondary payer statute, Medicare is authorized to make payment after the "promptly period" and before the one year time limit in 42 C.F.R. 424.44. According to 42 U.S.C. § 1395y(b)(2):

> (B) Conditional payment
>
> > (i) Authority to make conditional payment
> > [Medicare] may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or serve promptly…Any such payment by the Secretary shall be conditional on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

Therefore, a hospital or other health care service provider may, but is not required to, bill Medicare after the 120 day promptly period expires and before the one year Medicare timely filing period ends. During this time period (Day 121 to Day 365), a hospital can enforce its lien rights against the patient/client and charge the patient and the third-party automobile insurance carrier.

The Medicare Secondary Payer Manual promulgated by CMS confirms the above statutory scheme.[2] Paragraph 40.2 of the Manual provides that hospitals and other health care service providers must bill liability insurance prior to the expiration of the promptly period (120 days) rather than bill Medicare. After the expiration of the 120 day period, the hospital or provider may either: (i) bill Medicare for payment and withdraw all claims for recovery against the patient/client and the automobile insurance carrier/settlement; or (ii) maintain a claim or lien against the patient/client and the automobile insurance carrier/settlement. The Manual further provides that if the provider bills Medicare, it must accept Medicare's payment as payment in full and must not balance bill the patient/client or the automobile insurance carrier/settlement.

In our experience, hospitals generally do not bill Medicare during the above time frame and will roll the dice in an attempt to recover from the client's proceeds of the settlement with the automobile insurance carrier. How does Chapter 146 fit into this scheme? If a hospital does not timely bill Medicare as required by Chapter 146, do they run the risk of not recovering after the one year Medicare time limit expires?

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[2] Medicare Secondary Payer Manual 100-05:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c02.pdf

The only Texas case on point holds that a hospital may maintain its lien rights after the expiration of the one-year Medicare timely filing period ends. *Speegle v. Harris Methodist Health Sys*., 303 S.W.3d 32 (Tex. App.—Fort Worth 2009, pet. denied). This is a 2009 case out of the Ft. Worth Court of Appeals and is the only case that has directly addressed the issue of whether Chapter 146 conflicts with federal Medicare law.

The Ft. Worth Court of Appeals examined a 1995 memorandum issued by the predecessor agency to CMS which states that a hospital or other health care service provider may, but is not required to, bill Medicare for conditional payment if the liability insurance claim is not finally resolved. Relying on this 1995 memorandum, the court held that a provider like a hospital has the right to either bill Medicare or maintain a hospital lien after the expiration of the 120 day promptly period.

Because Chapter 146 conflicts with the secondary payer statutes and regulations, the Ft. Worth court held that Chapter 146 was preempted (unenforceable) to the extent it requires a hospital to bill Medicare. The hospital in that case was able to maintain its lien after the expiration of the time limits set forth in Chapter 146.

We think that the Ft. Worth Court of Appeals reached the wrong decision. We were able to retrieve an article directly from the CMS website that is in direct contravention of the *Speegle* case. The article is entitled *Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations* dated September 19, 2017 and is authored by the CMS Medicare Learning Network (the "2017 CMS Article").[3] According to the 2017 CMS Article, hospitals and other health care service providers are required to cease all collection efforts and remove all hospital liens after the one year timely filing period set forth in 42 C.F.R. 424.44(a)(1) expires. Verbatim, the 2017 CMS Article provides:

> **Q5. How long can a claim/lien be maintained against the liability insurer/the beneficiary's liability insurance settlement? (Can I direct bill/maintain my lien once Medicare's timely filing period has expired?)**
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> A5. CMS' liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or a beneficiary once the Medicare timely filing period expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period.
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> - All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider, physician, or other supplier bills Medicare or when Medicare's timely filing period has expired – whichever occurs first.

[3] 2017 CMS Article:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17018.pdf

- If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.
- All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.

In negotiations with the hospital, always include a copy of the 2017 CMS Article to combat the hospital's claim of lien.

There is also a 2000 U.S. Department of Health and Human Services memorandum on point (the "2000 Memorandum"). The 2000 Memorandum focuses on the issue presented here, namely whether a hospital may enforce its lien rights after the Medicare billing period has expired. The 2000 Memorandum concludes that a hospital may not enforce liens after that time. The 2000 Memorandum is based on a federal Medicare statute referred to as the "Provider Agreement" Statute, 42 U.S.C. § 1395cc. Under the Provider Agreement Statute, health care providers participating in the Medicare program may " not ... charge ... any individual or any other person for... services for which such individual is entitled to have payment made under [Medicare]." §1395cc(a)(1)(A)(i).

Beware, however, there is a Wisconsin Court of Appeals case that holds that the 2000 Memorandum does not trump a hospital's lien rights after the expiration of the one-year timely filing period ends. *Laska v. General Cas. Co.*, 830 N.W.2d 252 (Wisc. Ct. App. 2013). The court held that the 2000 Memorandum conflicted with the purpose of the Secondary Payor Statute, *i.e.*, to shift the responsibility of payment to other sources of recovery where possible. *Id*. at 261. According to the Wisconsin Court of Appeals, the 2000 memorandum would encourage hospitals and other providers to bill Medicare rather than gamble on whether the underlying claim would settle before the Medicare billing period expires in contravention of the secondary payer statutes and regulations. The court therefore upheld the hospital's lien rights.

Further, a pair of recent cases has severely limited a hospital's right to claim the "full" or "list" charges when asserting a hospital lien. The first case, *In re North Cypress Medical Center Operating Co., Ltd.*, No. 16-0851, 2018 WL 1974376 (Tex. April 27, 2018) (orig. proceeding, not yet released for publication), is from the Texas Supreme Court. In that case, Crystal Roberts was involved in an automobile accident in June 2015 and was taken to the emergency room at North Cypress Medical Center (NCMC). Roberts was uninsured and NCMC billed her for the services at its full "chargemaster" prices, totaling over $11,000. Roberts settled the third party claim for $17,380 attributing $9,404 to past medical expenses. Roberts attempted to negotiate its bill with NCMC but negotiations were unsuccessful. Roberts sued seeking a declaratory judgment that NCMC's charges were unreasonable in violation of Chapter 55 of the Property Code and its lien invalid to the extent it exceeded a reasonable and regular rate. NCMC counter claimed on a suit for a sworn account.

Roberts sought the following discovery in litigation:

- Please produce all contracts regarding negotiated or reduced rates for the hospital services provided to Plaintiff in which Defendant is a party, including those with Aetna, First Care, United Healthcare, Blue Cross Blue Shield, Medicare, and Medicaid.
- Please produce the annual cost report you are required to provide to a Medicare Administrative Contractor Medicare [sic], as a Medicare certified institutional provider for [Year of accident and 4 years prior]
- Please state the Medicare reimbursement rate for x-rays, CT scans, lab tests and emergency room services, as you performed on the Plaintiff on [DOA].
- Please state the Medicaid reimbursement rate for x-rays, CT scans, las tests and emergency room services, as you performed on the Plaintiff on [DOA].

NCMC objected to these discovery requests and moved for a protective order, asserting that the information requested was irrelevant and the requests over broad. Roberts filed a Motion to Compel. The trial court ordered NCMC to produce the requested information to include only contracts that covered the time period at issue in this case. NCMC filed a writ of Mandamus to the Court of Appeals which was denied. NCMC then filed a Mandamus action in the Texas Supreme Court. The issue before the Court was whether the information sought by Roberts was relevant and whether NCMC was required to produce the information sought by Roberts. The Court began its analysis with an examination of the hospital lien statute found in Texas Property Code Chapter 55.

The hospital lien statute gives a hospital a lien on the cause of action of a patient "who receives hospital services for injuries caused by an accident that is attributed to the negligence of another person." Tex. Prop. Code § 55.002(a). The hospital lien statute is replete with language that the hospital is entitled to recover the full amount of its lien, subject only to the right of the patient to question the reasonableness of the charges comprising the lien. *Id.; See also Daughters of Charity Health Servs. v. Linnstaedter,* 226 S.W. 3d 409,411 (Tex. 2007) (noting that the amount of a hospital lien may not exceed "a reasonable and regular rate.").

NCMC argued that the requested discovery was not relevant because Roberts was uninsured and the contracts between NCMC and private insurers and Medicaid and Medicare are not relevant to its charges to an uninsured patient. Because Roberts did not have any health insurance, NCMC argued that Roberts was not entitled to the benefit of those negotiated rates. Roberts, on the other hand, argued that the insurance contracts were necessary to establish whether the amount NCMC charged Roberts is excessive in comparison to the rates for the same services provided to insured patients in the same hospital. The Supreme Court sided with Roberts and ordered the hospital to produce the discovery in question.

The Supreme Court noted that a "two-tiered" healthcare billing structure has evolved in health care. Those tiers encompasses "list" or "full" rates which are sometimes charged to uninsured patients and frequently uncollected, and "reimbursement rates' for patients covered by government and private insurance. Few patients ever pay a hospital's full rate, but hospitals set charges as high as possible because that tends to increase hospital's reimbursement rates. Therefore, the "list" charges themselves are not dispositive of what is a "reasonable and regular rate" when determining the amount of the hospital's lien. The amounts a hospital accepts from other patients, including

those covered by private insurance and government benefits (Medicare, Medicaid, etc.) is relevant to whether the charges encompassed in a hospital lien are reasonable.

The following is the central holding of Texas Supreme Court in the *In re North Cypress* case:

> However, the issue whether Roberts may take advantage of insurance she did not have. Rather, because a valid hospital lien may not secure charges that exceed a reasonable and regular rate, the central issue in a case challenging such a lien is what a reasonable and regular rate would be? And because of the way chargemaster pricing has evolved, the charges themselves are not dispositive of what is reasonable, irrespective of whether the patient being charged has insurance. By contrast, a hospital's reimbursements from private insurers and public payers comprise the vast majority of its payments for services rendered. We fail to see how the amounts a hospital accepts as payment from most of its patients are wholly irrelevant to the reasonableness of its charges to other patients for the same services.

Additionally, a more recent case from the 12th Court of Appeals in Tyler is very helpful when dealing with a hospital lien where the client has Medicare or other insurance. *See East Texas Medical Center Athens v. Hernandez*, 053118 TXCA12, 12-17-00333-CV (delivered May 31, 2018). The court surprisingly does not address Chapter 146 specifically; however, the case stands for the proposition that a hospital may not bill a Medicare patient the full chargemaster rate by filing a hospital lien instead of billing Medicare.

Esther Hernandez was involved in an automobile accident in June of 2016 and she received medical services at East Texas Medical Center Athens (ETMC). Hernandez signed an assignment of benefits to ETMC and ETMC filed a hospital lien. The purpose of the hospital lien was to secure ETMC's right to recover from the responsible third party that caused the accident. The parties agreed that the amount that ETMC sought to recover exceeded $33,000.

Hernandez settled her claim with the third party. Hernandez requested to pay ETMC approximately $2,500. ETMC agreed to reduce its lien to $20,000. When the parties were unable to agree, Hernandez filed a declaratory judgment action asking the court to declare ETMC's bill excessive and unreasonable. In response, ETMC filed a motion to dismiss the lawsuit under the Texas Citizen's Participation Act (TCPA). The trial court denied ETMC's motion to dismiss and found that the TCPA did not apply because of the "commercial speech' exception found in the TCPA. ETMC appealed to the 12th Court of Appeals.

The sole issue on appeal was whether the trial court erred in denying ETMC's motion to dismiss under the TCPA, whose purpose is to "encourage and safeguard the constitutional rights of persons to petition, speak freely, associate freely, and otherwise participate in government to the maximum extent permitted by law, and at the same time, protect the rights of a person to file meritorious lawsuits for demonstrable injury. "Tex. Civ. Prac. & Rem. Code § 27.002.

Under the TCPA, lawsuit may be dismissed if the lawsuit "is based on, relates to, or is in response to a party's exercise of the right of free speech, the right to petition or right of association". *Id.* §

27.003. The party moving for dismissal (ETMC) has the initial burden to establish, by preponderance of the evidence, "that the legal action is based on, relates to, or is in response to the party's exercise of the right of free speech, the right to petition or the right of association. *Id.* § 27.005(b). If the movant (ETMC) meets this burden, the burden shift to the nonmovant (Hernandez) to show by "clear and specific evidence" a prima facie case in question. *Id.* § 27.005(c). Even if the plaintiff in the underlying action establishes a "prima facie" case, the court shall still dismiss the case if the movant (ETMC) establishes each essential element of a valid defense by a preponderance of the evidence. *Id.* § 27.005(d). In ruling on a motion to dismiss, the court is to consider the pleadings and supporting and opposing affidavits stating the facts on which the liability or defense is based. *Id.* § 27.006(a).

ETMC argued that Hernandez's lawsuit was based upon ETMC's filing of a hospital lien. Therefore, according to ETMC, Hernandez's cause of action is based upon ETMC's exercise of its right to petition and its exercise of its right to free speech. The court looked at the TCPA's definitions of "exercise of the right to petition" and "exercise of the right of free speech." *Id.* § 27.001(4) and § 27.001(3). The court found that Hernandez's lawsuit was in response to ETMC's exercise of the right of free speech, *i.e.*, the filing of the hospital lien was necessarily a communication that relates to health and the provision of medical services constituted a matter of public concern.

However, the TCPA does not apply to commercial speech. Under that exception, the TCPA does not apply to "a legal action brought against a person primarily engaged in the business of selling or leasing goods or services, if the statement or conduct arises out of the sale or lease of goods, services, or an insurance product, insurance services, or a commercial transaction in which the intended audience is the actual or potential buyer or customer." *Id.* § 27.1010(b). After thorough analysis, the Court of Appeals found that the commercial speech exemption applies to ETMC's conduct. Therefore, the court found that the trial court did not err in denying ETMC's motion to dismiss.

More importantly for our purposes, the Court went on to conclude that Hernandez established by clear and specific evidence a prima facie case for each essential element of her claim – that the hospital lien was unreasonable and excessive. The court noted that the hospital lien statute allowed the hospital to recover the full amount of its lien, subject only to the right of the patient to question the reasonableness of the charges comprising the lien. *Id.*

The court of appeals relied heavily on Texas Supreme Court decision, *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, No. 16-0851, 2018 WL 1974376 (Tex. April 27, 2018) (orig. proceeding, not yet released for publication) in holding that the hospital's lien was indeed reasonable. The court noted that Hernandez was covered by Medicare at the time of collision. The ETMC bill demonstrated its knowledge that Hernandez was covered by Medicare. The court then noted that "Federal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable. *Id.* (citing *Heygood v. De Escabedo*, 356 S.W. 3d 390, 392 (Tex. 2012)). Because the bill provided by ETMC contained a CT scan in excess of $30,000, the amounts billed by ETMC are most likely not the Medicare-approved rates. Thus, "the evidence supports Hernandez's contention that the amount charged by [ETMC], as reflected in the hospital lien, exceeds the reasonable and regular rate for the same or similar services. Thus,

such charges are not recoverable under the hospital lien." Hernandez met her burden of presenting evidence to support her contention that she was not charged the Medicare approved rate and a prima facie case that ETMC's charges exceeded the reasonable and regular rate in violation of the Texas Property Code Chapter 55.

The court further held that ETMC could not show the affirmative defense of quasi-estoppel by arguing that Hernandez had relied on the entire hospital bill in negotiations with the third-party in reaching her settlement.

The author wishes that the Tyler Court would have also determined whether ETMC violated CPRC Chapter 146; however, Chapter 146 was apparently not briefed by counsel or considered by the court. However, there are key takeaways from the holding in ETMC, as follows:

- Hospitals "reasonable and regular rate" is not the "list" of "full" price. Patients are entitled to discovery of hospitals reimbursement rates and hospitals have been dealt a huge blow by the Texas Supreme Court by *In re N. Cypress*.
- Federal law mandates that Medicare recipients may not be billed an amount more than Medicare has determined to be reasonable.

So where does that leave us with respect to Medicare and Chapter 146? Here are a few takeaways and pointers:

- The 2017 CMS Article and 2000 Memorandum are helpful and hold that a hospital may not maintain a lien after the expiration of the one year timely filing period. Use those instead of *Speegle* in your negotiations with the hospital. We find that often times the people we are dealing with at the hospital and their collection agencies have no actual grasp of the law. Sending a copy of the above with strong language that we are prepared to pursue a declaratory judgment action and seek attorney's fees may win the day.
- The only direct Texas case *Speegle* helps the hospital and holds that Chapter 146 doesn't apply to Medicare claims. This is only one case and is only applicable in the Ft. Worth court of appeals area. If you are outside of Ft. Worth (or want Ft. Worth to reconsider), rely on the 2017 CMS Article and 2000 Memorandum in your arguments. Also rely on the recent holdings of the *In re N. Cypress* (Texas Supreme Court) and *East Texas Medical Center* (Tyler Court of Appeals) discussed herein.
- If the hospital files a lien and your client has Medicare, wait until the one year timely filing period expires. There is no doubt that the hospital can maintain its lien rights during the first year after discharge.

Application of Chapter 146 and Medicaid

Medicaid is a federal-state jointly funded health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. Both the federal and state governments

have the responsibility to ensure that Medicaid is appropriately identifying potentially liable third parties and coordinating benefits to reduce Medicaid program costs. The individual states carry out the third party liability activities for Medicaid beneficiaries, including identifying third party resources, coordinating benefits during claims payment, filing claims and recovering payment for Medicaid benefits from settlements or awards made by liable third parties.

In Texas, the Texas Medicaid & Healthcare Partnership (TMHP), a group of private-public contractors, administers Texas Medicaid on behalf of the Texas Health and Human Services Commission (HHSC). TMHP is responsible for third-party liability recovery on behalf of Texas Medicaid.

CPRC 146.002(c) requires hospitals and other health care service providers to timely bill Medicaid generally before the first day of the eleventh month after the date of service. Like other forms of health insurance, Chapter 146.003 also provides that hospitals and other service providers that do not bill Medicaid pursuant to Chapter146.002 may not recover from the patient any amount that the patient would have been entitled to receive as payment or reimbursement under a health benefit plan or that the patient would not otherwise have been obligated to pay had the provider complied with Section 146.002.

Is there anything in the federal or state statutes or regulations that preempt the prompt billing requirements of Civil Practice & Remedies Code Chapter 146? Let's take a further look.

HHSC published *Texas Medicaid Procedure Manual: Volume 1* in July of 2018 (the "Medicaid Manual").[4] Section 8 of the Medicaid Manual is entitled "Third Party Liability" and has helpful information concerning a hospital's lien rights when a Medicaid recipient has Medicaid. Section 8.7 concerns Medicaid rules in accident claims. To ensure that Texas Medicaid is the payer of last resort, TMHP performs post-payment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client's right of recovery from personal insurance as a condition of Medicaid eligibility. An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified.

According to 8.7.1 of the Medicaid Manual, if payment is *immediately available* from a known third party such as Workers' Compensation or Personal Injury Protection (PIP) automobile insurance, that responsible party must be billed before Medicaid, and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is *substantially delayed* because of contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment.

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[4] Texas Medicaid Manual:
http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2017/Dec_2017%20TMPPM.pdf

The most likely situation that we encounter is when payment is *substantially delayed* because of contested liability or unresolved legal action (*i.e.*, settlement negotiations with the automobile insurance carrier are delayed or ongoing). In that case, the Medicaid Manual provides that the hospital may submit the bill to TMHP for payment.

Section 8.7.2 contains the rules for a hospital that desires to file a hospital lien in lieu of billing TMHP directly. Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid post-payment activities to be coordinated. A provider may file a lien for the entire billed amount only after meeting the criteria in Title 1 Texas Administrative Code (TAC) §354.2322. TAC §354.2322 severely neuters the rights of a hospital to pursue the client for services that would otherwise have been covered had the hospital submitted the claim to Medicaid. Summarizing TAC §354.23, the Medicaid Manual at 8.7.2 provides:

Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider submits an informational claim to TMHP within the claims filing deadline [95 day claim filing deadline].
- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

These burdens essentially null and void any hospital lien that the hospital may have against the client who has Medicaid. We have never seen a hospital send notice to the client or our office that contains a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid. According to TAC §354.23, the hospital is not allowed to bill the client for any Medicaid-covered services. Because Medicaid will cover virtually all hospital related charges in a scenario involving a car accident, it is difficult to think of any charges that a hospital could recover that are not covered by Medicaid. Further, the hospital must establish its own right of payment separate of any amounts claimed and established by the patient, yet in a tort action, the hospital does not have its own right of recovery against the third party or its insurer.

In the context of a client with Medicaid, there is nothing that prohibits application of Chapter 146. The regulations set forth by HHSC and TMHP support billing Medicaid when liability is contested and prohibit a hospital for filing a lien on charges that would be covered by Medicaid in the first place. Use Chapter 146 liberally when Medicaid is involved.

Application of Chapter 146 and TRICARE

TRICARE is the health care program for uniformed service members, retirees, and their families around the world. TRICARE provides comprehensive coverage to all beneficiaries, including comprehensive health insurance coverage. The TRICARE program is managed by the Defense Health Agency (DHA). We have the good fortune of representing many servicemen and servicewomen and their families in our practice. A hospital lien is invalid against a person covered by TRICARE as explained in more detail below.

TRICARE Operations Manual 6010.56-M, February 1, 2008, Claims Adjustments And Recoupments, Chapter 10, Section 5, Third Party Recovery Claims (the "TRICARE Manual")[5] sets forth the operating procedures where a hospital attempts to file a hospital lien or directly bill a person covered by TRICARE.

5.5.1 of the TRICARE manual provides that when a hospital submits a TRICARE claim for inpatient services, it becomes bound by the participating requirements. These require that hospitals accept the TRICARE-determined allowable amount as payment in full. Therefore, hospitals may not bill or otherwise seek recovery from the beneficiary (or file a lien against a beneficiary's liability insurance proceeds or recovery from a liable third party) for the difference between the billed charge and TRICARE-determined allowable amount. Hospitals attempting to do so shall be advised that this constitutes a violation of the TRICARE participation requirements, may constitute program fraud or abuse and may subject them to TMA administrative sanctions and the loss of their status as a TRICARE and Medicare provider.

5.5.2 of the TRICARE Manual provides that prior to submission of a TRICARE claim, the hospital is not precluded from seeking recovery of its billed charge directly from the liable third party or insurer, including auto or home owners insurance, no-fault auto or uninsured motorist coverage. However, *the hospital may not bill the beneficiary directly without filing a TRICARE claim*. Once a TRICARE claim is filed, *the hospital may not* seek recovery of any amount, other than the applicable beneficiary deductible and cost-share, from the beneficiary, the third party or the liability insurer because of the limitations imposed by the TRICARE participation requirements.
5.5.2 specifically provides that the hospital may not bill a client directly because of the limitations imposed by the TRICARE participation requirements. The Texas hospital lien statute is found in Chapter 55 of the Texas Property Code. Texas Property Code Section 55.002 provides that. "A hospital has a lien on a cause of action or claim of an individual who receives hospital services for injuries caused by an accident that is attributed to the negligence of another person." Because the hospital does not have an independent right of recovery against the tortfeasor or his or her insurance company, the only way to enforce its rights to recovery is by filing a lien against the

[5] Tricare Manual:
http://manuals.tricare.osd.mil/DisplayManualPdfFile/TR08/66/ChangeOnly/TO08/C10S5.PDF

injured patient's recovery. The TRICARE Manual prohibits any such attempt to recover from the TRICARE beneficiary.

In *MCG Health Inc. v. Owners Insurance et al.*, 2011 WL 197893 (Ga. Jan. 24, 2011), the Georgia Supreme Court refused to enforce a hospital lien where a patient was covered under TRICARE. The Supreme Court reasoned that the hospital, utilizing a hospital lien statute similar to Texas, could not collect against the automobile insurance company directly. According to the Court, TRICARE regulations do not provide any basis for a hospital to collect its treatment costs from a liable third party or their insurer. Under the Federal Medical Care Recovery Act, the federal government alone has the right of collection against liable third parties and their insurers. The Court further held that any "state law which interferes with the financing of healthcare claims for TRICARE beneficiaries is preempted as a matter of federal statutory and regulatory law."

Chapter 146 requires a hospital to bill a patient's health insurance, including TRICARE. There is nothing in the federal statutes or regulations that preempt the application of Chapter 146. If you or your client has TRICARE, the hospital is prohibited from any collection efforts against the TRICARE covered individual. Our office has used this provision regularly to thwart a hospital's efforts to balance bill or enforce lien rights against our clients who have TRICARE.

Conclusion

Chapter 146 is a mighty sword to help battle a hospital lien when a patient/client has private health insurance, Medicare, Medicaid or TRICARE or other health insurance. Remember that a hospital is required to bill such insurance promptly and there are serious savings for you or your client when the hospital fails to bill health insurance. Here are a few pointers to maximize recovery:

- Wait until the time limits set forth in Chapter 146 expire before negotiating with the hospital.
- Inform the hospital in writing of the existence of health insurance early in the process. That way, there can be no doubt that the hospital is on notice of the existence of the health insurance. Notify the hospital billing department once and once only. Don't push the point any further. If the hospital does not actually follow through and bill insurance, you can submit the entire bill to the automobile insurance adjuster as opposed to having a lower "paid or incurred" bill paid by the hospital.[6]
- If possible, settle the claim with the insurance company before negotiating with the hospital because of the problems associated with "paid or incurred" under CPRC 41.0105.
- In addition, utilize *In re N. Cypress* and *East Texas Medical Center* to contest the hospital's charges, regardless of whether client has insurance or not.

[6] See 41.0105 of the Texas Civil Practice and Remedies Code. Please be mindful that the defense could also use Chapter 146 to attack the hospital charges under 41.0105 and the holding in *Haygood v. de Escabedo*, 356 S.W.3d 390 (Tex. 2011).

- If needed, file a declaratory judgment action against the hospital to enforce Chapter 146 and seek attorney's fees under CPRC Chapter 37 (Texas Declaratory Judgement Act) when the hospital does not relinquish its lien.

Clark Harmonson is a personal injury lawyer licensed in Texas, New Mexico and Arizona. Harmonson Law Firm's office is located in El Paso, Texas and accepts cases throughout Texas, New Mexico and Arizona. Please feel free to call Clark at (915) 584-8777 if you have questions about this article or for a free consultation.