DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the
General Counsel

Region VI
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VIA U.S. MAIL and FAX (918) 745-0575

August 27, 2007

Esther M. Sanders
Sanders & Associates, P.C.
2727 East 21st Street, Suite 303
Tulsa, OK 74114-3534

Re: *Jack Horner v. Sate Smith Schwartz*, Case No. CJ-2004-3859 in the District Court of Tulsa County, Oklahoma, and Jack Horner, 512-40-6918A, DOI 3/1/6,

Dear Ms. Sanders:

This office represents the Centers for Medicare and Medicaid Services ("CMS"), the agency of the U.S. Department of Health and Human Services created by Congress to administer the Medicare program. CMS contractor in Oklahoma, Pinnacle Business Solutions, forward to us a Subpoena dated July 23, 2007, issued to Medicare Management Inc. in Oklahoma City, under the style of the case identified above. As I read it, the Subpoena generally seeks production for inspection and copying all documents related to Medicare beneficiary Jack Horner and his benefit history, documents showing Dr. Anthony C. Billings, M.D. to be a participating provider, and documents showing the obligations of participating providers (a very broad question indeed). An authorization for disclosure of related medical information was attached. The Subpoena requires an appearance by August 15 in Tulsa Oklahoma. The documents were not forwarded to the proper office until after that date.

Please note that CMS is the only party in interest for Medicare, and that no CMS employee or contractor can be compelled to appear in any proceeding in which the United States is not properly a party (e.g. state proceedings), nor can they be sanctioned for failure to appear. No request for testimony or documents can be honored except within the framework of the *Touhy* regulations at 45 C.F.R. Part 2 (issued under the authority of 5 U.S.C. § 301) . This includes proper presentation of a subpoena "to the Agency head ...and ...state the nature of the requested testimony, why the information sought is unavailable by any other means, and the reasons why the testimony would be in the interest of the DHHS or the federal government." 45 C.F.R. § 2.4(a). CMS is the only entity that can receive service of process in any matter related to Medicare, and such service must comport with Fed. R. Civ. P. 4(i) and 45 C.F.R. § 4.1.

Since the United States is not a party to the action identified above, the HHS *Touhy* regulations apply to the Subpoena:

> No employee or former employee of the DHHS may provide testimony or produce documents in any proceedings to which this part applies ...unless authorized by the Agency head pursuant to this part based on a determination by the Agency head, after consultation with the Office of the General Counsel, that compliance with the request would promote the objectives of the Department.

45 C.F.R. § 2.3. *See United States ex rel. Touhy v. Ragen*, 340 U.S. 462, 467, 95 L. Ed. 417, 71 S. Ct. 416 (1951). The regulation applies to all "state, local, and tribal judicial, administrative, and legislative proceedings, and to federal judicial and administrative proceedings." 45 C.F.R. § 2.1(c). An agency "employee" in this context includes "...any employees of health insurance intermediaries and carriers performing functions under agreements entered into pursuant to sections 1816 and 1842 of the Social Security Act, 42 U.S.C. 1395h, 1395u..." which includes Pinnacle employees. *See* 45 C.F.R. §§ 2.2, 5.5, and 5b.2(b)(1).

Because you provided with the subpoena an authorization to release the related medical records, CMS could proceed, pursuant to 45 C.F.R. § 2.5(b), as though the subpoena was a FOIA request. *See* 5 U.S.C. §§ 552(b)(3) and (b)(6); 45 C.F.R. § 5.67(a). Your request for information is denied to the extent it is sought improperly by Subpoena, in a court without jurisdiction over the Medicare issue of reimbursement under 42 U.S.C. § 1395y(b)(2), but will be forwarded to the regional FOIA officer to be processed as it might be otherwise under FOIA.

More specifically, your pleading presents questions that we can discuss further outside the context of the Subpoena. I have asked for a determination from CMS of whether Dr. Billings is a party to a Medicare provider agreement. If he is, the terms of that agreement incorporate all applicable statutory and regulatory provisions. Specifically, the statute requires a provider to bill Medicare for services for which the beneficiary is entitled under the law to have Medicare pay, to accept the amount Medicare pays in reimbursement for covered claims, and not to attempt further collection from the beneficiary or any other source for those items or services Medicare paid. This precludes filing a lien against a beneficiary's litigation in anticipation of a recovery. *See* 42 U.S.C. § 1395cc(a)(1) and 42 C.F.R. § 411.54(c)(i)-(iii). A provider who violates the terms of a provider agreement is subject to termination from the program. This limitation does not apply, however, to any deductible, co-pay, or item or service that Medicare does not cover, which the provider can properly seek to recover by any means not in conflict with the Medicare rules.

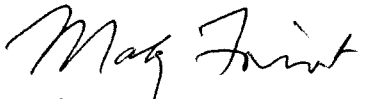
I understand you to have received a letter from a CMS contractor indicating that, up to the date of the letter, there were no relevant conditional payments on behalf of Jack Horner that were subject to reimbursement from any recovery in your action. I do not have a copy of a conditional letter in this case, and request that you fax a copy of any such letter to the number below. I hate to speculate without knowing the facts, but two reasons Medicare might not have recorded claims for Mr. Horner relevant to this incident might be 1) because he would have become eligible for Medicare based on his age over 2 weeks after the accident, and 2) the related providers might not have filed any relevant claims yet. A provider has the option to submit claims to Medicare for reimbursement at any time

1) on or before [December] 31 of the following year for services that were furnished during the first 9 months of the calendar year; and 2) on or before [December] 31 of the second following year for services that were furnished during the last 3 months of the calendar year.

42 C.F.R. § 424.44(a)(1). In this case, items or services provided in the first 6 months following the Date of Incident (DOI) would not be barred if submitted by December 31 of 2007. Those items and services provided after October 1, 2006 could properly be submitted to Medicare up until December 31, 2008.

Please feel free to call me on this matter at any time. I can be reached at (214) 767-3664, by fax at (214) 767-0907, or by e-mail at mark.forcier@hhs.gov .

Sincerely,



Mark Forcier
Assistant Regional Counsel

cc: Lindsey Kittrell