



TEXAS STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

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INVESTIGATIONS DIVISION

BOARD STATUTE & RULES REGULATORY HI-LITES

(Updated: 07/03/2015)

- **For regulatory and compliance purposes, what portions of the Board Statute and Rules should Podiatrists make sure they know?**

Although the entire Podiatric Medical Practice Act (Texas Occupations Code, Chapter 202), the Board Rules (Texas Administrative Code; Title 22, Part 18) and related other State/Federal Laws/Rules are quite extensive, from a "complaint" prevention perspective, it would be in a licensee's best interest to be aware of the following Board Statute & Rules, and related regulations.

Note: Formal "Disciplinary Actions" (Board Orders) are reported to the National Practitioner Databank (NPDB) and on the Board's website.

<http://www.tsbpme.texas.gov/verification.disciplinary.htm>

- **Applicants for a Texas Podiatry License will be tested (entirely) on:**

"Texas Occupations Code, Chapter 202" (Statute)

and

"Title 22-Part 18 Texas Administrative Code" (Rules)

This document is **NOT** an inclusive "Study Guide." Applicants **MUST** study the **ENTIRE** Board Statute & Rules which can also be found on the Board's website (www.tsbpme.texas.gov) by clicking on the "Statute & Rules" link.

<http://www.tsbpme.texas.gov/rules.htm>

► STATUTE & RULES TO KNOW:

◆ SCOPE OF PRACTICE:

Generally, regarding a podiatrist's scope of practice in Texas, as of July 30, 2010, the Texas Supreme Court had made a final decision on the podiatry scope of practice litigation involving the TSBPME/TPMA/TMA/TOA. Podiatry scope of practice had then been a matter for final determination to be decided by the Texas Legislature. The 82nd Legislative Session began in January 2011. By the conclusion of the 82nd Texas Legislative Session in May 2011, HB1980/Laubenberg & SB 1264/Uresti died in Committee. As no action was taken by the 82nd Texas Legislature on those identical/companion bills, podiatry scope of practice determinations continue to be made in reference to and in accordance with the March/May 2008 Texas 3rd Court of Appeals Opinions (upheld by the Texas Supreme Court on July 30, 2010) and the statutory definition of "Podiatry" which Texas Occupations Code §202.001(a)(4) provides: ""Podiatry" means the treatment of or offer to treat any disease, disorder, physical injury, deformity, or ailment of the human foot by any system or method. The term includes podiatric medicine."

For reference, a "Podiatry Scope of Practice – Staff Resource Information" document has been published on the agency's website at the following:

www.tsbpme.texas.gov/qa.htm#q1

The Board's website is updated as necessary/prudent to reflect any scope of practice changes.

Please review that document (& supporting/hyperlink information) from our website CAREFULLY as this is the Board's response to the litigation outcome. That document also speaks to certain hospital credentialing scenarios (i.e. Texas Health & Safety Code provisions). The practice of podiatry in Texas is limited to treatment of the "Foot/Ankle;" no other portions of the human anatomy.

Hospital Scenarios:

With regard to all credentialing/privileging issues, that is a matter for LOCAL CONTROL between the podiatrist and the facility in accordance, in part, with Texas Health & Safety Code Subchapter E relating to Medical Staff Membership & Privileges §241.101 et al. Privileges are granted by hospital credentialing committees upon consideration of a podiatrist's individual training, experience, certifications and qualifications. For any/all requested privileges, the podiatrist should demonstrate training and proficiency (e.g. via surgical logs or proctoring).

The Board is not authorized to order any hospital/facility to grant privileges to a podiatrist. The TSBPME does however recommend to all credentialing committees that they review a podiatrist's documented training prior to granting privileges. **Whether or not privileges are granted is a matter for local control.**

Again, each medical facility determines, locally, and individually, whether the podiatrist seeking credentials has the necessary skill, education, and training to perform specific procedures.

Individual Limitation Scenarios:

In recognition of proper practice for public safety, any podiatrist shall provide adequate and appropriate services consistent with best practices and community standards. A podiatrist shall maintain objectivity and shall respect each individual's dignity, and shall not engage in any action that may cause injury and shall always act with integrity in providing services.

A podiatrist shall recognize the limitations on the individual's ability and shall not offer services outside the individual's scope of practice, qualifications/training, and shall not use techniques that exceed the individual's professional competence. A podiatrist shall not claim, directly or by implication, to possess professional qualifications or affiliations that the podiatrist does not in fact possess.

A podiatrist must also not exceed the scope of practice of "Podiatry" by engaging in the unauthorized practice of some other regulated activity such as "Medicine" (MD/DO; Texas Medical Board). At all times, a podiatrist must remain within the "Podiatry" scope of practice and must clearly identify himself/herself as a "Podiatrist, DPM, Podiatric Physician, Etc."

Again, of utmost importance to the Board is assurance that a podiatrist NOT exceed "Podiatry" scope of practice and does NOT engage in the unauthorized practice of "Podiatry" or "Medicine" (MD/DO; the field licensed/regulated by the Texas Medical Board).

A podiatrist must also ensure that he/she is not allowing others to practice "Podiatry" who are not licensed to do so, and that one does not violate "Podiatry" laws by exceeding the "Foot/Ankle" scope of practice limitation for "Podiatry/Podiatric Medicine" or by engaging in the unauthorized practice of some other regulated activity. Performing or allowing the unauthorized practice of "Podiatry/Podiatric Medicine" is a criminal act pursuant to Texas Occupations Code §202.605, punishable by fine/county jail confinement.

◆ BOARD STATUTE:

- §202.001(4) Definition of "PODIATRY"
- §202.003 Application of Chapter
- §202.059 Meetings
- §202.060 Location of Offices
- §202.151 General Rulemaking Authority
- §202.155 Contracts With Other State Agencies
- §202.253 Grounds for Denial of License
- §202.262 Display of License
- §202.263 Issuance of Duplicate or Amended License
- §202.301 Annual License Renewal
- §202.303 Practice Without Renewing License
- §202.402 Scope of Privilege
- §202.406 Consent For Release of Confidential Information
- §202.501 Board Disciplinary Powers; Administrative Procedure
- §202.502 Revocation/Suspension for Drug related Felony Conviction
 - JUST SAY "NO" TO DRUGS → License Revoked upon Final Conviction
- §202.503 Probation; Hearing

- §202.504 Reissuance of License
- §202.507 Subpoena Authority
- §202.5085 Refund
- §202.510 Temporary Suspension of License
- §202.558 Collection of Penalty
- §202.601 Injunction
- §202.6015 Cease and Desist Order
- §202.605 General Criminal Penalty: Practicing Without License (Fine, Confinement, Both)
 - ACTIVATE & RENEW YOUR LICENSE
- §202.606 Criminal Penalty: Amputation of Foot (Fine, Confinement, Both)

◆ **BOARD RULES:**

- Chapter 373 Rules Governing Advertising & Practice Identification (entire chapter).
 - Notify Board of Practice and Trade names.
 - Properly identify your designation as a: “Doctor of Podiatric Medicine; DPM; Podiatrist; Podiatric Physician; Foot Surgeon, Podiatric Surgeon, Foot Specialist, Doctor and Surgeon of the Foot, Injuries and Diseases of the Foot, ... Etc.”
 - The purpose of this subsection and of so limiting the professional designations of a Podiatric Physician and his/her practice's business is to insure that the public and all prospective patients are reasonably informed of the distinction between Podiatric Physicians and other medical practitioners as is reflected by the difference in training and licensing and the scope of practice.
 - Do **NOT** identify yourself as a “Physician; Medical Doctor; MD/DO” as that is the practice of “Medicine” (MD/DO) under the licensure and regulation of the Texas Medical Board.
 - \$500.00 fine per Advertising/Identification violation; per each day.
 - All Podiatric Physicians shall retain recordings, transcripts, or copies of all public communications by date of publication for a period of at least 2 years after such communication was made.
- Chapter 375 Rules Governing Conduct & Scope of Practice (entire chapter)
 - Refer to the "Podiatry Scope of Practice – Staff Resource Information" document published on the agency’s website (as aforementioned).
 - O.k. to use “Ankle” in an advertisement; but submit all advertisement and trade name layouts to the Board for approval first.
- Chapter 376 Rules Governing Violations & Penalties (entire chapter)
 - Jurisdictional complaints investigated by the Board include, but are not limited to, allegations involving: Death, Substance Abuse, Fraud, Negligence, Advertising, Fees, Records, Inappropriate Physician Behavior, Impaired Physician and Office Inspections.

◆ **MISCELLANEOUS:**

- The Texas State Board of Podiatric Medical Examiners is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the Board is abolished September 1, 2017.

- The Board is composed of 9 Members (6 practicing Podiatrists; 3 Public members) appointed by the Governor of Texas & confirmed by the Senate; all serve staggered 6 year terms.
- Formal “Disciplinary Actions” (Board Orders) are reported to the NPDB-HIPDB & on the Board’s Website. Board actions are a permanent part of the licensee’s record at the Board office.
- Please give your patients proper & written “PRE-OP” and “POST-OP” instructions.
- Medical Records: 30 calendar days to provide to patient; can charge reasonable fee.
- Orthotics: develop an “Agreement” form explaining costs and general lack of insurance coverage. www.tsbpme.texas.gov/complaint.htm
- Re-pay your state/federal student loans or license will be suspended!!!
- Pay your child support or license will be revoked/suspended!!!
- Please, please, please practice only within the Scope of Practice for Podiatric Medicine!!!
- The **TSBPME** is **NOT** the Texas Medical Board **NOR** the Texas Podiatric Medical Association!!! Know who issues your STATE license to practice Podiatric Medicine.
- Additional “Questions & Answers” information can be found here on the agency’s website: <http://www.tsbpme.texas.gov/qa.htm>

► MORE SPECIFIC COMMON VIOLATIONS:

◆ BOARD STATUTE:

- §202.253: Entire Section & following highlights.
- §202.253(a)(3): Abuse of drugs.
- §202.253(a)(4): All types of Fraud; not billing within scope/Medicaid & Medicare; Private.
- §202.253(a)(6): Advertisement; not using certifying boards full name when saying “board certified” in ad. Not identifying self as “DPM”, “Podiatric Physician”, etc. Example: “Dr. John Doe” alone is not proper. Must identify “Podiatric” specialty. “John Doe, DPM...” is proper.
- §202.253(a)(7): Boasting or laudatory comments used in advertisements.
- §202.253(a)(13): Employing unlicensed individuals.
- §202.253(a)(15): Additional drug, age, mental capacity issues.
- §202.253(a)(16): Catch All: Lack of conservative care (especially with diabetic patients), no “informed consent” form completed prior to treatment. No or not enough discussion of treatment plan, potential for bad outcome and fees to be paid, dirty offices and surgery areas (clean vs. sterile), assaultive personas and poor “people” skills, double billing, etc.
- §202.253(a)(17): Hospital disciplinary action for by-laws violations, general negligence, incompetence (i.e. failed surgeries).
- §202.502: Abuse of prescription and recreational drugs.
- §202.552: The amount of an administrative penalty may not exceed \$5,000.00. Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.
- §202.605: Activating license after passing exam and obtaining a license.

◆ BOARD RULES:

- Chapter 373: All types of advertising violations, from boasting to not using “D.P.M.”
- §375.3: No conservative or follow-up care, boasting a 100% positive outcome.
- §375.9: In order for the public to be informed regarding the functions of the Board and the Board's procedures by which complaints are filed with and resolved by the Board, each licensee is required to display in each podiatric medical office information regarding the Board's name, address, and telephone number. The licensee must display a sign furnished by the Board or provide to all patients and consumers a brochure that notifies consumers or recipients of services of the name, mailing address, and telephone number of the Board and a statement informing consumers or recipients of services that complaints against a licensee can be directed to the Board. The sign shall be conspicuously and prominently displayed in a location where it may be seen by all patients. The consumer brochure, if chosen, must be prominently displayed and available to patients and consumers at all times.
- §375.15: Too many civil disputes for business deals (partnerships, contracts for one doc to work in other doc’s office) going bad and causing complaints over who “owns” the patient records, who is responsible for keeping the patient records and following up on their care, etc.
- §375.19: No “informed consent” and discussion of fees and costs with patients.
- §375.21: Provision of patient records within 30 days unless one of the Exemptions for provision of the records applies. Licensees are often refusing to provide records to patient or other doctor due to suspicion of potential for lawsuit, etc. This is not an acceptable reason for failure to provide patient records.
- §375.23: Must report malpractice claims, especially at renewal time on Renewal form. At any other time, must report within 30 days of receipt of claim
- §375.33: Sexual Misconduct violations with patients and staff (**3 Levels: Sexual Violation, Sexual Impropriety; Sexual Exploitation**). **Know your “Professional Boundaries” !!!**
- Chapter 376: Regarding violations, within 20 days after the date the licensee receives the proposed order, the licensee may, in writing, accept the determination and recommended penalty, disciplinary action of the Executive Director or Investigator, propose a counter-offer, or may request, in writing, a hearing on the occurrence of the violation and the amount of the penalty.
- Chapter 378: Obtain 50 hours of CME for biennium (i.e. 50 hours every 2 years). Must keep CME records in Podiatrist’s office for 4 years; subject to random audit and must submit upon request of the Board. A licensee who completes more than the required 50 hours

during the preceding CME period may carry forward a maximum of 10 hours for the next CME period. The penalty for non-compliance with the bi-annual CME requirement shall be a letter of reprimand and/or an administrative penalty per violation up to the maximum allowed by law.

- Records Retention: Advertising - 2 years; CME - 4 years; Patient/Medical - 5 years. (These are minimum retention periods.)

► **HEALTH CARE & INSURANCE FRAUD** **(MEDICARE / MEDICAID / PRIVATE PAY):**

- Do **NOT** commit (any type of) Fraud; many local/state/federal/private agencies have jurisdiction to investigate.
- TxHSC §311.0025 “Audits of Billing” of hospitals and facilities for suspicious claims.
- **Bill responsibly** to insurance companies; both private and government.
- If your license isn’t “Activated”, then every bill/claim you submit is fraudulent and you are also practicing without a license (General Criminal Penalty).
- If you bill for services outside the scope of practice for Podiatric Medicine, then every claim is considered fraudulent and is a scope of practice violation. This includes the unauthorized practice of “Medicine” (MD/DO; Texas Medical Board) by a Podiatrist.
- **To report suspected "Medicare/Medicaid Fraud, Waste & Abuse" call toll free 1-800-HHS-TIPS (1-800-447-8477).** This service is a product of the United States Department of Health & Human Services - Office of Inspector General.

<https://forms.oig.hhs.gov/hotlineoperations/>

◆ **FBI’S “2010-2011 FINANCIAL CRIMES REPORT TO THE PUBLIC”:**

"On white-collar crime...", the Federal Bureau of Investigation (FBI) publishes a "Financial Crimes Report to the Public" which can be located on the FBI's website.

<https://www.fbi.gov/stats-services/publications>

The FBI is the primary investigative agency in the fight against HCF and has jurisdiction over both the federal and private insurance programs.

Additional information sourced from the FBI is as follows:

What is Health Care Fraud?: 1) Altered or fabricated medical bills and other documents. 2) Excessive or unnecessary treatments. 3) Billing schemes, such as: charging for a service more expensive than the one provided, charging for services that were not provided, duplicate charges, 4) False or exaggerated medical disability and 5) Collecting on multiple policies for the same illness or injury.

General Overview: The FBI’s mission in health care fraud (HCF) is to oversee the FBI’s HCF initiatives by providing national guidance and assistance to support HCF investigations targeting individuals and organizations who are defrauding the public and private health care systems. The FBI works closely with its federal, state, and local law enforcement partners; the Centers for

Medicare and Medicaid Services (CMS); and other government and privately sponsored program participants to address vulnerabilities, fraud, and abuse.

All health care programs are subject to fraud; however, Medicare and Medicaid programs are the most visible. Estimates of fraudulent billings to health care programs, both public and private, are estimated between 3 and 10 percent of total health care expenditures. The fraud schemes are not specific to any area, but they are found throughout the entire country. The schemes target large health care programs, public and private, as well as beneficiaries. Certain schemes tend to be worked more often in certain geographical areas, and certain ethnic or national groups tend to also employ the same fraud schemes. The fraud schemes have, over time, become more sophisticated and complex and are now being perpetrated by more organized crime groups.

Emerging Trends and Projections: HCF is expected to continue to rise as people live longer. This increase will produce a greater demand for Medicare benefits. As a result, it is expected that the utilization of long- and short-term care facilities such as skilled nursing, assisted living, and hospice services will expand substantially in the future. Additionally, fraudulent billings and medically unnecessary services billed to health care insurers are prevalent throughout the country. These activities are becoming increasingly complex and can be perpetrated by corporate-driven schemes and systematic abuse by providers.

The most recent CMS statistical estimates project that total health care expenditures are estimated to total \$2.4 trillion, representing 14 percent of the gross domestic product (GDP). By the year 2016, CMS estimates total health care spending to exceed \$4.14 trillion, representing 19.6 percent of the GDP.

With health care expenditures consistently increasing, it is especially important to coordinate all investigative efforts to combat fraud within the health care system. The FBI is the primary investigative agency in the fight against HCF and has jurisdiction over both the federal and private insurance programs. With more than \$1 trillion being spent in the private sector on health care and its related services, the FBI's efforts are crucial to the success of the overall program. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the U.S. Health and Human Services - Office of Inspector General (USHHS-OIG), the Food and Drug Administration (FDA), Drug Enforcement Administration, Defense Criminal Investigative Service, Office of Personnel Management, IRS-CID, and various state and local agencies. On the private side, the FBI is actively involved with national groups such as the National Health Care Anti-Fraud Association and the National Insurance Crime Bureau (NICB), as well as many other professional and grassroots efforts to expose and investigate fraud within the system.

Collaboration: In furtherance of the FBI's efforts to combat HCF in the United States, the FBI participates in various initiatives with federal, state, and local agencies. At the Headquarters level, the FBI participates in a senior level working group which includes the CMS, DOJ, USHHS-OIG, and other agencies to identify and assess health care industry vulnerabilities and make recommendations to protect the industry and the public through a coordinated effort. At the Headquarters level, the FBI is also involved in coordination meetings at the DOJ which include various DOJ components involved in the fight against HCF. National-level liaison is also maintained with federal law enforcement agencies, the National Association of Medicaid Fraud Control Units, and other partners.

Throughout the country, FBI field offices participate in HCF working groups which involve law enforcement agencies, prosecutors, regulatory agencies, and health insurance industry professionals to identify the various crime problems involving HCF. The FBI develops national and local initiatives when large-scale fraud is detected, which may involve participation by several FBI field offices and other law enforcement agencies.

During the past year, the FBI continued to identify and analyze industry fraud trends through input from private and public health care program experts. Present areas of concern include DME; hospital fraud; physician fraud; home health agencies; beneficiary-sharing; chiropractic, pain management, and associated drug diversion; physical therapists; prescription drugs; multidisciplinary fraud; and identity theft which involves physician identifiers used to fraudulently bill government and private insurance programs.

As part of their national strategy to address HCF, the FBI cooperates with the DOJ and the various USAOs throughout the country to pursue offenders through parallel criminal and civil remedies. These cases typically target large-scale medical providers, such as hospitals and corporations, who engage in criminal activity and commit fraud against the government which undermines the credibility of the health care system. As a result, a great deal of emphasis is placed on recovering the illegal proceeds through seizure and forfeiture proceedings as well as substantial civil settlements. Upon the successful conviction of HCF offenders, the FBI provides assistance to various regulatory and state agencies, which may seek exclusion of convicted medical providers from further participation in the Medicare and Medicaid health care systems.

Data Mining Techniques: The FBI and the health care industry continue to expand their technology and intelligence assessments through the use of sophisticated data-mining techniques to identify patterns of fraud, systemic weaknesses, and aberrant billing activity.

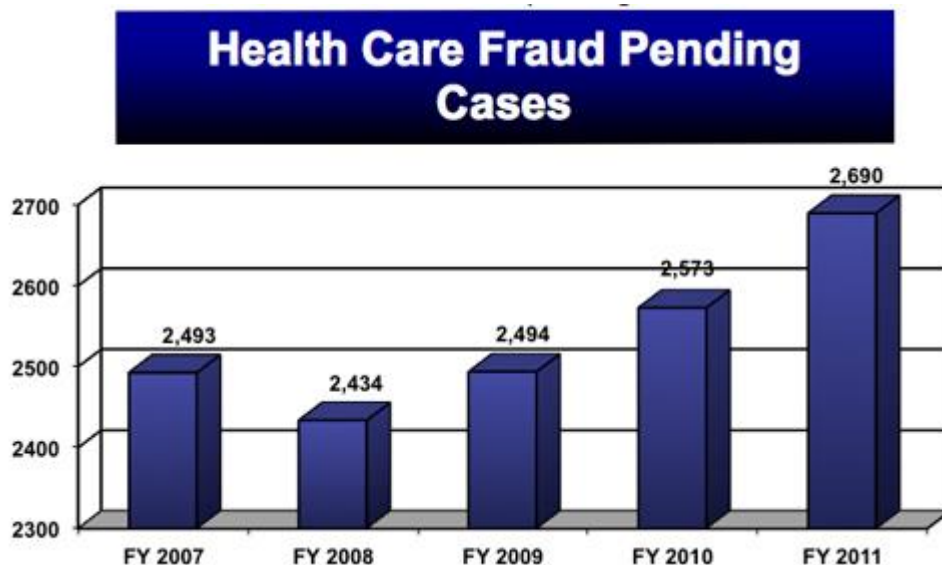
In 2005, the FCS developed the Electronic Bank Records Initiative (EBRI). The EBRI was implemented to identify and develop a process for obtaining electronic (digital format) records from financial institutions. Historically, financial institutions have provided paper copies of records to law enforcement when they receive a subpoena from the government. These records are generally maintained by the banks in an electronic format. The time it takes the financial institution to make the copies of the records and for the investigative agencies to return the paper copies back to an electronic format for financial analysis creates a severe negative effect on the timeliness, effectiveness, and efficiency of investigations. In an effort to increase the efficiency of the process, a subpoena attachment was developed by the DOJ, FBI, and IRS-CID for the production of electronic records instead of paper copies. The development included significant coordination with the financial institutions and their associations. The subpoena attachment was not based upon new or expanded laws, regulations, or rules. The attachment is merely meant to standardize and clarify the requests for electronic records according to the current federal rules of criminal and civil procedure. In general terms, if a financial institution maintains records electronically, the requesting agency would be seeking to obtain the records electronically. In addition, the scope of the records requested has not changed due to the subpoena attachment, with the exception of seeking the records electronically.

The subpoena attachment was disseminated to FBI offices, IRS offices, and throughout the DOJ in November 2007. The goal of the DOJ, FBI, and IRS-CID is to inform and prepare financial institutions and their respective agencies for the use and response to the subpoena attachment.

This includes working with financial institutions during the transition period in coordinating the requests and associated responses to subpoenas. In addition, it is anticipated the EBRI will greatly increase the efficiency of the financial records production process and provide significant costs savings to both the government and private industry.

Overall Accomplishments: Through FY 2011, 2,690 cases investigated by the FBI resulted in 1,676 informations/indictments and 736 convictions of HCF criminals. It should be noted that numerous cases are pending plea agreements and trials. The following notable statistical accomplishments are reflective in FY 2011 for HCF: \$1.2 billion in restitutions; \$1 billion in fines; \$96 million in seizures; \$320 million in civil restitution; and over \$1 billion in civil settlements.

The chart below reflects HCF pending cases from FY 2007 through FY 2011.



Health Care Fraud Schemes: HCF is carried out by many segments of the health care system using various methods. Some of the most prevalent schemes include:

Billing for Services not Rendered: These schemes can have several meanings and could include any of the following: 1) No medical service of any kind was rendered. 2) The service was not rendered as described in the claim for payment. 3) The service was previously billed and the claim had been paid.

Upcoding of Services: This type of scheme involves a billing practice where the health care provider submits a bill using a procedure code that yields a higher payment than the code for the service that was truly rendered. The upcoding of services varies according to the provider type. Examples of service upcoding include: 1) A routine, follow-up doctor's office visit being billed as an initial or comprehensive office visit. 2) Group therapy being billed as individual therapy. 3) Unilateral procedures being billed as bilateral procedures. 4) 30-minute sessions being billed as 50+ minute sessions.

Upcoding of Items: A medical supplier is upcoding when, for example, the supplier delivers to the patient a basic, manually propelled wheelchair, but bills the patient's health insurance plan for a more expensive motorized version of the wheelchair.

Duplicate Claims: A duplicate claim usually involves a certain item or service for which two claims are filed. In this scheme, an exact copy of the claim is not filed a second time; rather, the provider usually changes a portion, most often the date of service on the claim, so that the health insurer will not realize the claim is a duplicate. In other words, the exact claim is not filed twice, but one service is billed two times, in an attempt to be paid twice for one service.

Unbundling: This is the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost. For example, clinical laboratory tests may be ordered individually, or in a "panel" (i.e., a lipid panel, an arthritis panel, a hepatitis panel). Billing tests within each panel as though they were done individually on subsequent days is an example of unbundling.

Excessive Services: These schemes typically involve the provision of medical services or items which are in excess of the patient's actual needs. Examples of excessive services include: 1) A medical supply company delivering and billing for 30 wound care kits per week for a nursing home patient who only requires a change of dressings once per day. 2) Daily medical office visits conducted and billed for when monthly office visits would be more than adequate.

Medically Unnecessary Services: A service is medically unnecessary and may give rise to a fraudulent scheme when the service is not justified by the patient's medical condition or diagnosis. For example, a claim for payment for an electrocardiogram test may be fraudulent if the patient has no conditions, complaints, or factors which would necessitate the test.

Kickbacks: A health care provider or other person engages in an illegal kickback scheme when he or she offers, solicits, pays, or accepts money, or something of value, in exchange for the referral of a patient for health care services that may be paid for by Medicare or Medicaid. A laboratory owner and doctor each violate the Anti-Kickback Statute when the laboratory owner pays the doctor \$50 for each Medicare patient a doctor sends to the laboratory for testing.

Although kickbacks are often paid in cash based on a percentage of the amount paid by Medicare or Medicaid for a service, kickbacks may take other forms such as jewelry, free paid vacations, or other valuable items.

Health Care Fraud Prevention Measures: HCF is not a victimless crime. It increases health care costs for everyone. It is as dangerous as identity theft. Fraud has left many thousands of people injured. Participation in HCF is a crime. Keeping America's health system free from fraud requires active participation from each of us. The large number of patients, treatments, and complex billing practices attracts criminals skilled in victimizing innocent people by committing fraud.

Tips to Protect Yourself Against Health Care Fraud: 1) Protect your health insurance information card like a credit card, 2) Beware of free services—is it too good to be true?, 3) Review your medical bills, such as your "explanation of benefits," after receiving health care services. Check to ensure the dates and services are correct to ensure you get what you paid for

and 4) If you suspect HCF, contact your insurance company. You can also contact your local FBI field office and/or the local Department of USHHS-OIG Office (1-800-HHS-TIPS).

◆ **FEDERAL "STARK LAW" INFORMATION:**

Federal "Stark Law" information can be obtained from the Centers for Medicare & Medicaid Services (CMS).

<http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html?redirect=/Physicianselfreferral/>

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is also known as the "Physician Self-Referral" law and commonly referred to as the "Stark Law".

Information relating to a March 26, 2013 "Special Fraud Alert: Physician-Owned Entities" published by the United States Department of Health & Human Services - Office of Inspector General can be found at the link below.

http://www.tsbpme.texas.gov/agencydocuments/POD_Special_Fraud_Alert-March2013.pdf

"Federal Stark Law / False Claims Act / Anti-Kickback Statute / Physician Self-Referral Law" complaints should be filed directly to the United States Department of Health & Human Services - Office of Inspector General at:

<http://oig.hhs.gov/compliance/physician-education/01laws.asp>

◆ **TEXAS "ANTI-SOLICITATION LAW" INFORMATION:**

Texas Anti-Solicitation laws can be found at Texas Occupations Code Chapter 102 "Solicitation of Patients" ... **providing for administrative, civil and criminal penalties.**

<http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.102.htm>

Texas Occupations Code; Title 3. Health Professions; Subtitle A. Provisions Applying to Health Professions Generally; Chapter 102. Solicitation of Patients" provides that:

Subchapter A. General Provisions

§102.001. Soliciting Patients; Offense. (a) A person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency. (b) Except as provided by Subsection (c), an offense under this section is a Class A misdemeanor. (c) An offense under this section is a felony of the third degree if it is shown on the trial of the offense that the person: (1) has previously been convicted of an offense under this section; or (2) was employed by a federal, state, or local government at the time of the offense.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.002. Rebuttable Presumption. *It is a rebuttable presumption that a person violated Section 102.001 if: (1) the person refers or accepts a referral of a patient to an inpatient mental health facility or chemical dependency treatment facility; (2) before the patient is discharged or furloughed from the facility, the person pays the referring person or accepts payment from the facility for outpatient services to be provided by the referring person after the patient is discharged or furloughed from the facility; and (3) the referring person does not provide the outpatient services for which payment was made and does not return to the facility the payment received for those services.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.003. Federal Law; Construction. *Section 102.001 permits any payment, business arrangement, or payment practice permitted by 42 U.S.C. Section 1320a-7b(b) or any regulation adopted under that law.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.004. Applicability to Advertising. *Section 102.001 does not prohibit advertising, unless the advertising is: (1) false, misleading, or deceptive; or (2) not readily subject to verification, if the advertising claims professional superiority or the performance of a professional service in a superior manner.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.005. Applicability to Certain Entities. *Section 102.001 does not apply to: (1) a licensed insurer; (2) a governmental entity, including: (A) an intergovernmental risk pool established under Chapter 172, Local Government Code; and (B) a system as defined by Section 1601.003, Insurance Code; (3) a group hospital service corporation; (4) a health maintenance organization that reimburses, provides, offers to provide, or administers hospital, medical, dental, or other health-related benefits under a health benefits plan for which it is the payor; or (5) a health care collaborative certified under Chapter 848, Insurance Code.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.542, eff. Sept. 1, 2003. Amended by: Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.05, eff. September 28, 2011.

§102.006. Failure to Disclose; Offense. *(a) A person commits an offense if: (1) the person, in a manner otherwise permitted under Section 102.001, accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency; and (2) does not, at the time of initial contact and at the time of referral, disclose to the patient: (A) the person's affiliation, if any, with the person for whom the patient is secured or solicited; and (B) that the person will receive, directly or indirectly, remuneration for securing or soliciting the patient. (b) Except as provided by Subsection (c), an offense under this section is a Class A misdemeanor. (c) An offense under this section is a felony of the third degree if it is shown on the trial of the offense that the person: (1) has previously been convicted of*

an offense under this section; or (2) was employed by a federal, state, or local government at the time of the offense.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.007. Applicability. *(a) This subchapter does not apply to a health care information service that: (1) provides its services to a consumer only by telephone communication on request initiated by the consumer and without charge to the consumer; (2) provides information about health care providers to enable consumer selection of health care provider services without any direct influence by a health care provider on actual consumer selection of those services; (3) in response to each consumer inquiry, on a nondiscriminatory basis, provides information identifying health care providers who substantially meet the consumer's detailed criteria based on consumer responses to standard questions designed to elicit a consumer's criteria for a health care provider, including criteria concerning location of the practice, practice specialties, costs and payment policies, acceptance of insurance coverage, general background and practice experience, and various personal characteristics; (4) does not attempt through its standard questions for solicitation of consumer criteria or through any other means to lead a consumer to select or consider selection of a particular health care provider for health care provider services; (5) identifies to a consumer: (A) all health care providers substantially meeting the consumer's stated criteria who are located within the zip code area in which the consumer elects to obtain services from a health care provider; or (B) all health care providers substantially meeting the consumer's stated criteria who are located in zip code areas in the closest proximity to the elected zip code area if no health care provider substantially meeting the consumer's criteria is located within that zip code area; (6) discloses to each consumer the relationship between the health care information service and health care providers participating in its services; (7) does not provide or represent itself as providing diagnostic or counseling services or assessment of illness or injury and does not make any promise of cure or guarantee of treatment; (8) does not provide or arrange for transportation of a consumer to or from the location of a health care provider; (9) does not limit the scope of or direct its advertising or other marketing of its services to a particular health care provider specialty, to a particular segment of the population, or to persons suffering from a particular illness, condition, or infirmity; (10) charges to and collects a fee from a health care provider participating in its services that is set in advance, is consistent with the fair market value for those information services, and is not based on the potential value of a patient to a health care provider or on the value of or a percentage of the value of a professional service provided by the health care provider; (11) does not limit participation by a health care provider in its services to a particular health care specialty or to a particular service provided by a health care provider; (12) does not limit participation by a health care provider in its services for a reason other than: (A) failure to have a current license without limitation to practice in this state; (B) failure to maintain professional liability insurance while participating in the service; (C) significant dissatisfaction of consumers of the health care information service that is documented and can be proved; (D) a decision by a peer review committee that the health care provider has failed to meet prescribed standards or has not acted in a professional or ethical manner; or (E) termination of the contract between the health care provider and the health care information service by either party under the terms of the contract; (13) maintains a*

customer service department to handle complaints and answer questions for consumers; (14) maintains a customer follow-up system to monitor consumer satisfaction; and (15) does not use, maintain, distribute, or provide for any purpose any information that will identify a particular consumer, such as a name, address, or telephone number, obtained from a consumer seeking its services other than for the purposes of: (A) providing the information to the health care provider with whom an appointment is made; (B) performing administrative functions necessary to operate the health care information service; (C) providing directly to a consumer, at the request of that consumer on that consumer's initial contact with the health care information service, information relating to health-related support groups or providers of health-care-related services or equipment within the area of interest requested by the consumer; or (D) conducting analytical research on data obtained through provision of services and preparing statistical reports that generally analyze that data but do not in any manner identify one or more specific consumers. (b) In this section: (1) "Health care information service" means a person who provides information to a consumer regarding health care providers that can enable the consumer to select one or more health care providers to furnish health care services. (2) "Health care provider" means a person licensed, certified, or registered by a state health care regulatory agency other than: (A) a mental health facility as defined by Section 571.003, Health and Safety Code; or (B) a treatment facility as defined by Section 464.001, Health and Safety Code.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.008. Disciplinary Action. A violation of Section 102.001 or 102.006 is grounds for disciplinary action by the regulatory agency that issued a license, certification, or registration to the person who committed the violation.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.009. Injunction. (a) The attorney general or the appropriate district or county attorney, in the name of the state, may institute and conduct an action in a district court of Travis County or of a county in which any part of the violation occurs for an injunction or other process against a person who is violating this subchapter. (b) The district court may grant any prohibitory or mandatory relief warranted by the facts, including a temporary restraining order, temporary injunction, or permanent injunction.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.010. Civil Penalties. (a) A person who violates this subchapter is subject to a civil penalty of not more than \$10,000 for each day of violation and each act of violation. In determining the amount of the civil penalty, the court shall consider: (1) the person's previous violations; (2) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation; (3) whether the health and safety of the public was threatened by the violation; (4) the demonstrated good faith of the person; and (5) the amount necessary to deter future violations. (b) The attorney general or the appropriate district or county attorney, in the name of the state, may institute and conduct an action authorized by this section in a district court of Travis County or of a county in which any part of the violation occurs. (c) A penalty collected under this

section by the attorney general shall be deposited to the credit of the general revenue fund. A penalty collected under this section by a district or county attorney shall be deposited to the credit of the general fund of the county in which the suit was heard.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.011. Suit for Injunctive Relief or Assessment of Civil Penalty. *(a) The party bringing a suit under this subchapter may: (1) combine a suit to assess and recover civil penalties with a suit for injunctive relief; or (2) file a suit to assess and recover civil penalties independently of a suit for injunctive relief. (b) The party bringing the suit may recover reasonable expenses incurred in obtaining civil penalties, injunctive relief, or both, including investigation costs, court costs, reasonable attorney's fees, witness fees, and deposition expenses. (c) The civil penalty and injunction authorized by this subchapter are in addition to any other civil, administrative, or criminal action provided by law.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

Subchapter B. Healing Arts

§102.051. Soliciting Patients; Offense. *(a) A person commits an offense if the person: (1) practices the art of healing with or without the use of medicine; and (2) employs or agrees to employ, pays or promises to pay, or rewards or promises to reward another for soliciting or securing a patient or patronage. (b) A person commits an offense if the person accepts or agrees to accept anything of value for soliciting or securing a patient or patronage for a person who practices the art of healing with or without the use of medicine. (c) An offense under this section is a misdemeanor punishable by a fine of not less than \$100 or more than \$200. Each violation of this section is a separate offense. (d) For purposes of this section, a person who practices the art of healing includes a masseur and an optometrist.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.052. Applicability to Physicians. *This subchapter does not apply to a practitioner of medicine subject to regulation under Subtitle B.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.053. Exception for Certain Advertising. *Section 102.051 does not prohibit: (1) placement in a newspaper of an advertisement of the person's profession, business, or place of business; or (2) advertisement by handbill and payment for services in distributing the handbill.*

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

§102.054. Accessibility and Use of Witness Testimony. *(a) A person is not exempt from giving testimony in a proceeding to enforce Section 102.051. (b) The testimony a person gives in a proceeding to enforce Section 102.051 may not be used*

against that person in any criminal action or proceeding. A criminal action or proceeding may not be brought against a person because of the testimony given by that person in a proceeding to enforce Section 102.051.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

"Texas Anti-Solicitation - Solicitation of Patients" complaints & "Deceptive Trade Practices" complaints should be filed directly to the Texas Attorney General's Office - Consumer Protection Division at:

<https://www.texasattorneygeneral.gov/cpd/file-a-consumer-complaint>

Board Rule §375.3 “General” provides that:

“(a) The health and safety of patients shall be the first consideration of the Podiatric Physician. The principal objective to the podiatric profession is to render service to humanity. A Podiatric Physician shall continually strive to improve his medical knowledge and skill for the benefit of his patients and colleagues. The Podiatric Physician shall administer to patients in a professional manner and to the best of his ability. Secrets and personal information entrusted to him shall be held inviolate unless disclosure is necessary to protect the welfare of the individual or the community. A Podiatric Physician shall be temperate in all things in recognition that his knowledge and skill are essential to public health, welfare, and human life. (b) A licensed podiatric physician shall conduct his practice on the highest plane of honesty, integrity, and fair dealing and shall not mislead his patients as to the gravity of such patient's podiatric medical needs. A podiatric physician shall not abandon a patient he has undertaken to treat. He may discontinue treatment after reasonable notice has been given to the patient by the podiatric physician of his intention to discontinue treatment and the patient has had a reasonable time to secure the services of another podiatric physician or all podiatric medical services actually begun have been completed and there is no contract or agreement to provide further treatment.”

**PRACTICE
“COMMON SENSE & GOOD JUDGMENT”**