August 8, 2019

VIA ELECTRONIC MAIL to comments@tdi.texas.gov

Comments
Texas Department of Insurance
Austin, Texas

Re: Stakeholder meeting on Senate Bill 1264 rules

Dear Commissioner Sullivan,

On behalf of the Texas Medical Association (“TMA”), we appreciate this opportunity to offer additional comments on the Texas Department of Insurance’s (“TDI” or “the Department”)’s efforts to implement SB 1264. In particular, we would like to comment on the question posed by you at the SB 1264 stakeholder meeting on July 29, 2019 regarding the threshold issue of the extent to which TDI has jurisdiction over the subject matter of SB 1264 and more specifically, the regulation of physicians subject to SB 1264.

At the stakeholder meeting, your questions regarding authority/jurisdiction over the regulation of physicians in the context of SB 1264 were posed to TMA President, David C. Fleeger, MD. As Dr. Fleeger and you both noted at the time, Dr. Fleeger is a physician, not a lawyer. As such, Dr. Fleeger was present at the stakeholder meeting for the purpose of offering testimony concerning the operational aspects of SB 1264, not its legal implications. Thus, a jurisdictional/statutory authority question is outside of Dr. Fleeger’s scope and has been referred by Dr. Fleeger to us, in our capacity as legal counsel for TMA, for response.

Consequently, we are writing this letter to clarify some points regarding TMA’s position on the scope of TDI’s jurisdiction/authority under SB 1264. First, we note that the plain language of SB 1264 itself makes it clear that, even in the context of SB 1264, the Texas Medical Board (“TMB”)—not TDI—remains the state agency with regulatory and enforcement authority over Texas’ physicians and the practice of medicine, which includes a physician’s billing. After SB 1264, TDI’s regulatory and enforcement authority remains where the Texas Legislature has always placed it (i.e., focused on state-regulated health benefit plan issuers in Texas).

With that being said, TDI does have certain express rulemaking authority regarding the implementation of the out-of-network claim arbitration process as set forth in SB 1264 and discussed more fully below. TDI’s rulemaking on arbitration, to the extent authorized by the Legislature, has a great potential to affect physicians as well as other health care providers in this state. However, it does not extend into regulating a physician’s ability to bill and/or taking
enforcement actions against physicians (as discussed more fully, below). In promulgating rules to implement the arbitration process, it is imperative that TDI carefully abide by the bounds of its statutorily authorized rulemaking authority. TMA would strongly oppose any attempt by the Department to enforce the law and regulations against physicians.

I. Regulatory and Enforcement Authority With Regard to Physicians Subject to SB 1264 Remains with the TMB, Not the TDI.

Under existing law, the Texas Legislature has consistently recognized the TMB as the primary means of licensing, regulating, and disciplining physicians.\(^1\) The Legislature included language expressly stating this intent in the Medical Practice Act itself\(^2\) and reiterated the TMB’s overarching authority over physicians through numerous other statutory provisions, including through its broad grant of authority to the TMB to: (1) regulate the practice of medicine in this state\(^3\) and (2) discipline physicians for committing an act that violates any state or federal law if the act is connected with the physician’s practice of medicine.\(^4\)

Similarly, the Texas Legislature has recognized TDI as the state agency responsible for the regulation of the business of insurance in this state.\(^5\) The plain language of SB 1264 does nothing to disturb this well-established, longstanding statutory framework, setting forth separate jurisdictional spheres for these two state agencies. In fact, the Legislature included numerous provisions in SB 1264 itself that not only recognize but also reinforce the respective, bifurcated jurisdictions of these two state agencies.

A. As Stated in SB 1264, Enforcement of Violations of SB 1264’s Prohibition on Balance Billing or a Law that Imposes a Requirement Related to that Prohibition Resides with the TMB as Applied to Physicians.

First, Section 752.0003 of the Texas Insurance Code, as added by SB 1264, which sets forth enforcement authority regarding violations of SB 1264’s prohibitions on balance billing, states as follows:

Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured’s, participant’s, or enrollee’s managed care plan or that imposes a requirement related to that prohibition.

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1 Tex. Occ. Code §151.003.
2 Id.
3 See, e.g., Tex. Occ. Code §§ 152.001 and 153.001(3).
4 Tex. Occ. Code §§164.051(a)(1); 164.052(a)(5); 164.053(a)(1).
(b) The department may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.
(c) A regulatory agency described by Subsection (a) or the commissioner may adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this subsection.

Under the express statutory language of Section 752.0003, the TMB, as the “appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician… to practice… in this state” is the agency with the authority to take disciplinary action against a physician who violates a law that prohibits the physician from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured’s participant’s or enrollee’s managed care plan or that imposes a requirement related to that prohibition. Conversely, TDI does not “license[], certif[y], or otherwise authorize[]” a physician to practice in this state and, therefore, very clearly falls outside this express grant of statutory authority for enforcement related to the bill.

Consistent with the TMB and TDI’s existing statutory authority (and the traditional jurisdictional scope of the respective state agencies), the Legislature intended a bifurcation in enforcement authority here—the health care licensing/certifying agencies enforce the law with regard to health care providers within their respective jurisdictions and TDI enforces the law with regard to health plan issuers in its jurisdiction. This fact is made abundantly clear with the language in subsection (b) that further specifies that “TDI may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.”

Furthermore, subsection (c) authorizes a regulatory agency described by subsection (a) or the commissioner, respectively, to adopt rules necessary to implement the section. From the context of the law, it is clear that the scope of those rules must be consistent with the bifurcated authority listed in subsections (a) and (b). In other words, the state agencies regulating health care providers are authorized to promulgate rules regarding enforcement provisions applicable to the health care providers within their respective jurisdictions, and TDI is authorized to implement rules regarding enforcement provisions applicable to health benefit plan issuers and administrators within its jurisdiction.

Next, Section 752.0002 of the Texas Insurance Code, as added by SB 1264, states as follows:

Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) If the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured’s, participant’s, or enrollee’s managed care plan or that imposes a requirement
related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

(b) If the attorney general prevails in an action brought under Subsection (a), the attorney general may recover reasonable attorney’s fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action. (emphasis added).

The Department will note that subsection (a) refers to “the appropriate regulatory agency” making a referral regarding a pattern of intentionally violating a law that prohibits balance billing or that imposes a requirement related to that prohibition. “The appropriate regulatory agency” for purposes of referring alleged violations by Texas physicians is, once again, the TMB and “the appropriate regulatory agency” for purposes of referring alleged violations by Texas health plan issuers/administrators is the Department. The Legislature used the “appropriate regulatory authority” language for economy of words in order to avoid listing all affected regulatory agencies individually, given the wide array of individuals and entities falling within the scope of SB 1264 while, once again, simultaneously recognizing the division of enforcement responsibilities between state licensing agencies for health care providers and TDI for health plan issuers/administrators as referenced in the subsequent section of the law (i.e., Section 752.0003, Texas Insurance Code).

Recognition of the Legislature’s bifurcation of enforcement authority in SB 1264 is vital to ensuring that there is proper vetting by the licensing agency that has enforcement authority prior to referral to the attorney general in order to avoid undue burden and expense to both the state and the affected health care provider or health plan issuer/administrator. It is important that TDI honor this statutory language and its intended division of authority. Thus, under the express terms of the law, TDI is only authorized to refer alleged violations regarding health benefit plan issuers and administrators to the attorney general.

B. As Stated in SB 1264, Express Authority to Enforce the Bad Faith Arbitration Provisions and Any Other Violation of Subchapter B-1 of Chapter 1467 Applied to Physicians Resides with the TMB.

Next, in Section 1467.101 of the Texas Insurance Code, as amended by SB 1264, the Legislature sets forth various conduct that constitutes bad faith participation in arbitration. Once again, by its plain language, the Legislature made it clear that TMB is the state agency with enforcement authority over an alleged physician violation of this provision (as well as over any violation of Subchapter B-1—the entire arbitration subchapter) by stating in Section 1467.102(a) that “bad faith participation or otherwise failing to comply with Subchapter B-1 is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who committed the violation.” Very clearly this is, once again, a grant of enforcement authority to the respective licensing body for the actor (i.e., the TMB as applied to physicians and TDI as applied to health benefit plan issuers who are granted a license or certificate of authority to operate in Texas).
C. As Stated in SB 1264, Investigations and Complaints That Relate to the Settlement of An Out-of-network Health Benefit Claim Subject to Chapter 1264 As Applied to Physicians Remains with the TMB.

Finally, in Section 1467.151(a) of the Texas Insurance Code, the Legislature once again makes explicit in its regulatory and enforcement framework that authority for investigating and reviewing complaints filed that relate to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467 remains with the respective agency with traditional jurisdiction over the individual or health plan issuer (i.e., “The commissioner and the Texas Medical Board or other regulatory agency, as appropriate, shall adopt rules regulating …”). This division in regulatory/enforcement authority is further evidenced in subsection (b) which notes that “the department and Texas Medical Board or other appropriate regulatory agency shall maintain information on each complaint that concerns a claim, arbitration, or mediation subject to this chapter, including . . . (5) any other information about: (A) the health benefit plan issuer or administrator that the commissioner by rule requires; or (B) the out-of-network provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.” (emphasis added).

Taken in total, the enforcement provisions discussed above (i.e., §§ 752.0002-.0003, 1467.101-102, and 1467.151, Insurance Code) cover the entire scope of the subject matter of SB 1264 as applied to physicians from the prohibition on balance billing (or a law that imposes a requirement related to that prohibition) to the arbitration process to investigation of complaints related to the settlement of an out-of-network health benefit claim subject to Chapter 1467. Thus, it is readily apparent from the plain language of SB 1264 that the Texas Legislature intended for the TMB—and not TDI—to enforce SB 1264 as applied to physicians.

II. SB 1264 Granted TDI Limited Rulemaking Authority Related to the Arbitration Process. That Rulemaking Authority Does Not Extend to the Regulation of Physician Billing.

A. TDI’s Rulemaking Authority Is Limited to the Arbitration Process Itself.

As stated above, the Legislature has made it abundantly clear that enforcement over alleged physician violations associated with SB 1264 lies with the TMB (both through specific provisions in the bill and the TMB’s general enforcement authority over physicians committing an act violating state or federal law if the act is connected with the physician’s practice of medicine). Thus, TDI’s authority (including rulemaking authority) does not, in any way, extend to enforcing SB 1264 against physicians. Additionally, TDI’s rulemaking authority under SB 1264 does not extend its policy-making authority to encompass the regulation of a physician’s ability to bill (which falls squarely within the jurisdiction of the TMB).

Rather, SB 1264 grants the following rulemaking authority to TDI, which is limited to the arbitration process itself:

- Section 1467.082(b)—requires the commissioner to: (1) adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration
program, including the establishment of a portal on the department’s internet website through which a request for arbitration may be submitted and (2) maintain a list of qualified arbitrators for the program;

- Section 1467.084(c)—requires the person who requests the arbitration to provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to: (1) the department; and (2) each other party;

- Section 1467.084(e)—requires the commissioner to adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding;

- Section 1467.086(d)—requires the commissioner to immediately terminate the approval of an arbitrator who no longer meets the requirements of the subchapter and rules adopted under the subchapter to serve as an arbitrator; and

- Section 1467.088(c)—requires the arbitrator to provide written notice in the form and manner prescribed by commissioner rule of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, it requires the parties to provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement.

The other legislative grants of rulemaking authority to TDI under SB 1264 are limited to TDI’s traditional scope of regulation (i.e., regulation of health benefit plan issuers and administrators) or apply in the context of mediation which does not apply to physicians. Among those provisions are the following:

- Section 752.0003(c)—allows the Department to adopt rules as necessary to implement the section (regarding disciplinary action against a health benefit plan issuer or administrator for violating a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure).

- Sections 1271.008(a)(3), 1301.010(a)(3), 1551.015(a)(3), 1575.009(a)(3), and 1575.009(a)(3)—requires an explanation of benefits provided to the physician or provider to include information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467;

- Section 1467.003(a)—requires the commissioner, the TMB and any other appropriate regulatory agency to adopt rules as necessary to implement their respective powers and duties under Chapter 1467;

- Section 1467.006(d)—authorizes the commissioner to adopt rules governing the submission of information for the benchmarking database used in the arbitration process;
• Sections 1467.0505(b)(1), 1467.052(d), and 1467.054(b-1)—concern commissioner rulemaking related to mediation (which only apply to a health benefit claim submitted by an out-of-network provider that is a facility); and

• Section 1467.151(a)—requires the commissioner and the TMB or other appropriate regulatory agency, as appropriate, to adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467, Insurance Code.

Historically, TDI has recognized the limitations of its jurisdictional authority with regard to balance billing issues. For example, in the 2013 Biennial Report to the Legislature, TDI noted the Texas Legislature is the “only entity with policymaking authority over all parties” in balance billing/out-of-network claims disputes and that TDI’s preferred provider benefit plan (PPO) rules represented “TDI’s best efforts to protect consumers and meet legislative mandates within the confines of TDI’s authority.”

Nothing in SB 1264 has changed the jurisdictional limits of TDI’s authority to now permit it to regulate a physician’s ability to bill or charge.

B. TDI’s Rulemaking Authority Does Not Extend to the Out-of-Network Disclosure Exemption.

Given the context above of TDI’s limited rulemaking authority under SB 1264, it is important to revisit a subject of much discussion at the stakeholder meeting on July 29 (i.e., that regarding the out-of-network disclosure exception to SB 1264’s prohibitions on balance billing).

The out-of-network disclosure exceptions under SB 1264 (i.e., §§ 1271.157(d), 1271.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d), and 1579.111(d)) permit a physician to balance bill where otherwise prohibited under the law for a nonemergency health care or medical service:

(1) That an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and
(2) For which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:
   (A) Explains that the physician or provider does not have a contract with the enrollee’s health plan;
   (B) Discloses projected amounts for which the enrollee may be responsible; and
   (C) Discloses the circumstances under which the enrollee would be responsible for those amounts.

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Importantly, the disclosure exceptions listed above determine when a physician may balance bill. As noted above, this is a subject matter that TDI itself has noted to be outside of its jurisdiction (and which continues to be outside of TDI’s jurisdiction after the passage of SB 1264).

Laws regulating physician billing have been, and continue to be, within the purview of the TMB. For example, the TMB has authority to take action against a physician who violates Section 311.0025, Health and Safety Code, which prohibits a physician from submitting to a patient or a third party payor a bill for a treatment that the professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

The TMB has taken many disciplinary actions against physicians related to billing issues, including improper billing violations. See Attachment A from some examples from the TMB’s Bulletins.

Additionally, it is important to note that the very definition of “practicing medicine” as set forth in the Texas Medical Practice Act includes billing for services.

‘Practicing medicine’ means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method or the attempt to effect cures of those conditions, by a person who:

(A) Publicly professes to be a physician or surgeon; or
(B) Directly or indirectly charges money or other compensation for those services.

For TDI to attempt to regulate physician billing (and implement the disclosure form exceptions of SB 1264) would be an attempt to regulate the practice of medicine and is, therefore, outside its statutory authority. Once again, as noted above, the TMB is the state agency with the power to regulate the practice of medicine, not TDI.

Certainly, given SB 1264’s numerous (over 15) references to commissioner rules, the Texas Legislature was well aware of its ability to grant TDI rulemaking authority under SB 1264 when and where it so desired if it wanted to alter the existing jurisdictional spheres of the agencies. However, it declined to do so with regard to the disclosure exceptions to the prohibition on balance billing. This declination (along with the express enforcement framework under SB 1264 as applied to physicians being placed squarely and repeatedly with the TMB) clearly demonstrates the Legislature’s deference to the traditional jurisdictional scopes of the TMB and TDI.

TDI should not disrupt the Legislature’s well-established jurisdictional framework. If rules are to be promulgated to implement the disclosure exceptions under §§ 1271.157(d), 1271.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d),

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7 Id.
8 See also, TEX. OCC. CODE §§ 101.203 and 164.053(a)(7).
9 TEX. OCC. CODE § 151.002(a)(13). (emphasis added).
and 1579.111(d) of the Insurance Code, the TMB must be the agency developing and adopting those rules as applied to physicians (as the TMB has express statutory authority to adopt rules to perform its duties and regulate the practice of medicine in this state). TDI certainly may provide input to aid the TMB in its development of those rules (with the goal of having more uniform rules across agencies), but the rules themselves are in the jurisdictional purview of the TMB as they entail the regulation of physicians.

Additionally, we see value in TDI working with the TMB to create a form to aid in utilization of the statutory exceptions to the prohibition on balance billing. As TMA noted in prior comments, this form should not be mandated by TDI (again, that would be outside of TDI’s jurisdictional authority), but it should be made available by the TMB and TDI to facilitate the exception process.

III. Conclusion

As the Commissioner of Insurance, we appreciate the seriousness with which you take compliance with the law, and we appreciate your inquiry into stakeholder opinions as to the appropriate scope of the Department’s authority/jurisdiction in the implementation of SB 1264. We hope that this letter clarifies TMA’s position on this matter.

Please feel free to contact us directly with any additional questions regarding statutory authority at TMA’s general line at 800-880-1300 or at rocky.wilcox@texmed.org or kelly.walla@texmed.org.

Sincerely,

Donald P. “Rocky” Wilcox, JD
TMA Vice President and General Counsel

Kelly M. Walla, JD, LLM
TMA Associate Vice President and Deputy General Counsel

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10 TEX. OCC. CODE § 153.001.
ATTACHMENT A

Select Examples of TMB Disciplinary Actions Related to Billing
(All examples, below, are excerpted from TMB Bulletins)\textsuperscript{11}

Marrow, Charles Taylor, III, M.D., Lic. No. E4006, Texarkana
On February 10, 2012, the Board and Charles Taylor Marrow, III, M.D., entered into an Agreed Order requiring Dr. Marrow to undergo an independent medical evaluation by a psychiatrist, have his practice monitored by a physician for eight monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam and complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours in supervising mid-level practitioners. The Board found Dr. Marrow failed to meet the standard of care, violated guidelines for standing delegation orders, improper billing, failure to adequately supervise and aiding or abetting unlicensed practice of medicine.\textsuperscript{12}

Salzer, Thomas, M.D., Lic. No. J5638, College Station
On June 3, 2011, the Board and Thomas Salzer, M.D., entered into an Agreed Order requiring Dr. Salzer to complete within one year eight hours of CME in risk management and complete within one year an ICM-coding course with in-person attendance. The action was based on Dr. Salzer’s unprofessional conduct when he submitted an improper billing statement.\textsuperscript{13}

Elemuren-Ogunmuyiwa, Iyabo Abiola, M.D., Lic. No. K4050, Harker Heights
On October 18, 2013, the Board and Iyabo Abiola Elemuren-Ogunmuyiwa, M.D., entered into an Agreed Order publicly reprimanding Dr. Elemuren-Ogunmuyiwa and requiring Dr. Elemuren-Ogunmuyiwa to have her practice monitored by another physician for eight monitoring cycles; and within one year complete at least eight hours of in-person CME in the topic of proper billing practices. The Board found Dr. Elemuren-Ogunmuyiwa engaged in unprofessional conduct for improper billing. Specifically, Dr. Elemuren-Ogunmuyiwa was under investigation concerning her Tri-Care patient charts.\textsuperscript{14}

Killyon, Garry W., M.D., Lic. No. M2673, Sugar Land
On May 1, 2014, the Board approved a Final Order requiring Garry W. Killyon, M.D., to within one year complete at least 25 hours of CME, divided as follows: 10 hours in medical record-keeping, 10 hours in CPT code billing, and five hours in ethics; have his billing practices monitored by a billing monitor for four consecutive monitoring cycles; and pay an administrative penalty of $5,000 within 60 days. The Board found Dr. Killyon in connection with his performance of surgeries and billing under CPT Code 11471, submitted billing statements that he knew or should have known were improper and failed to maintain medical records to support the billing for CPT code 15734. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the

\textsuperscript{11} See TMB Bulletins for additional examples: http://www.tmb.state.tx.us/docs/docs
\textsuperscript{12} TMB Bulletin (March 2012) at p. 17; available at: http://www.tmb.state.tx.us/dl/8FF059B0-176A-943A-424E-5041AA8867B7
\textsuperscript{13} TMB Bulletin (Jan. 2012) at p. 44; available at: http://www.tmb.state.tx.us/dl/D2AD4731-293E-5791-06AF-6D16BB612085
\textsuperscript{14} TMB Bulletin (Dec. 2013) at p. 10; available at: http://www.tmb.state.tx.us/dl/2E5228C5-82E6-07E3-6CE4-E8ACEC322FAF
State Office of Administrative Hearings. Dr. Killyon has 20 days from the service of the order to file a motion for rehearing.15

Porto, Boris Joseph, M.D., Lic. No. H4621, Lubbock
On June 12, 2015, the Board and Boris Joseph Porto, M.D., entered into an Agreed Order requiring Dr. Porto to have his practice monitored by another physician for eight consecutive monitoring cycles; comply with the terms of his pre-trial diversion agreement with Texas Health and Human Services (HHSC) and provide evidence to the Board upon completion of the agreement; and within one year complete at least eight hours of CME in proper billing. The Board found Dr. Porto was subject to a pre-trial diversion agreement, entered in March 2014, with HHSC related to billing Medicaid for services “not rendered as billed” for patients in a group home.16

On June 10, 2016, the Board and Adolphus Ray Lewis, D.O., entered into an Agreed Order After Formal Filing publicly reprimanding Dr. Lewis and requiring Dr. Lewis to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in proper billing practices and eight hours in ethics; and within six months pay an administrative penalty of $6,000. The Board found the evidence indicated a pattern of poor billing practices on the part of Dr. Lewis and that Dr. Lewis failed to document a minimal history for all patients at issue. This order resolves the formal complaint filed at the State Office of Administrative Hearings.17

Yarra, Subbarao, M.D., Lic. No. K3882, McAllen
On June 10, 2016, the Board and Subbarao Yarra, M.D., entered into an Agreed Order requiring Dr. Yarra to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in peripheral vascular intervention; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Yarra violated the standard of care with regard to eight patients by overestimating the true degree of stenosis on their angiographies and billed the patients for the procedures which lacked adequate documentation or justification.18

Mego, Pedro Antonio, M.D., Lic. No. M1925, McAllen
On June 10, 2016, the Board and Pedro Antonio Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in coronary angiography; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to six patients. Three patient’s carotid ultrasounds were based on inadequate documentation, and four patient’s coronary computed tomographies were based on inadequate

16 TMB Bulletin (August 2015) at p. 15; available at: http://www.tmb.state.tx.us/dl/41514F2A-954E-F5CF-10F5- FBA7D75A28C9
17 TMB Bulletin (July 2016) at p. 27; available at: http://www.tmb.state.tx.us/dl/3E6AEB22-664A-0ABF-F89B- 25FB4B7979DD
18 Id. at p. 13.
documentation, and therefore, were unnecessary. A coronary stent performed for one patient was also not indicated. Dr. Mego billed for these unnecessary procedures based on the inadequate documentation and failed to maintain adequate medical records for the patients.\(^\text{19}\)

**Mego, Carlos David, M.D., Lic. No. K6147, McAllen**

On June 10, 2016, the Board and Carlos David Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least eight hours of CME in medical recordkeeping; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to four patients whose ultra-sounds were based on inadequate documentation and were billed for the unnecessary diagnostic testing.\(^\text{20}\)

**Benavides, Richard Alex, M.D., Lic. No. F9189, Dallas**

On August 25, 2017, the Board and Richard Alex Benavides, M.D., entered into a Mediated Agreed Order requiring him to within 60 days pay an administrative penalty of $4,000. The Board found Dr. Benavides did not document the necessary components to justify billing codes for five patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.\(^\text{21}\)

**Nawaz, Mohammad, M.D., Lic. No. L2497, Frisco**

On August 25, 2017, the Board and Mohammad Nawaz, M.D., entered into an Agreed Order requiring him to have his billing practice monitored for 8 consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in ethics and eight hours in billing and coding; and shall comply with any and all terms of his Pre-Trial Diversion Agreement. The Board found that on February 20, 2015, Dr. Nawaz signed a Pre-Trial Diversion Agreement in U.S. District Court related to allegations of false billing claims.\(^\text{22}\)

\(^{19}\) *Id.* at p. 12.

\(^{20}\) *Id.*

\(^{21}\) TMB Bulletin (September 2017) at p. 20; *available at*: [http://www.tmb.state.tx.us/dl/A1BB2B98-02FD-3A3C-9022-D99248F0EEBF](http://www.tmb.state.tx.us/dl/A1BB2B98-02FD-3A3C-9022-D99248F0EEBF)