No. 97880-8

SUPREME COURT OF
THE STATE OF WASHINGTON

No. 78910-4

COURT OF APPEALS, DIVISION ONE
OF THE STATE OF WASHINGTON

HUNG DANG, MD,
Petitioner,
v.

WA STATE DEPARTMENT OF HEALTH MEDICAL QUALITY ASSURANCE COMMISSION,
Respondent

PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER

Petitioner is Hung Dang, MD, the Appellant in the Court of Appeals.

II. CITATION TO COURT OF APPEALS DECISION

The Decision, Hung Dang, M.D. v. WA State Dept of Health, Medical Quality Assurance Commission, filed in the Court of Appeals Division I on August 19th, 2019. Motion for Reconsideration was denied but Motion to Publish was granted on October 23rd, 2019. Appendix A.

III. ISSUES PRESENTED FOR REVIEW

A. Whether MQAC's Amended Final Order is illegal and void and thus cannot be affirmed for violating mandatory statutory time limits of RCW 34.05.461(8)(a), .470(3) and res judicata.

B. Whether MQAC is pre-empted from concurrent jurisdiction over EMTALA (App. B), a statute with exclusive federal jurisdiction; If so, whether RCW 18.130.180(7) supersedes the Supremacy Clause of the US Constitution and its well-established jurisprudence.

C. Whether RCW 18.130.180(1) and (4) prohibit a physician from exercising his or her speech and independent medical judgement.

D. Whether MQAC must find a duty of care as a matter of law to legally conclude that a physician commits "Incompetence, Negligence, or Malpractice" and "Practice[s] Below the Standard of Care", consistent with legal standards well-settled by the WA Supreme Court and Court of Appeals.

IV. STATEMENT OF THE CASE

On June 8th, 2014, I did not have the physical capacity to care for Patient C due to my orthopedic injuries and explicitly declined his transfer. CP 1168, 1176, 1301-2, 1170-5. Dr. Moore accepted that patient

transfer without even talking to me. CP 907, 1368; MQAC Finding of Fact (FOF) 1.17. A board-certified emergency physician and licensed in WA, she is trained and experienced in needle aspirations of tonsillar abscesses. CP 1332-3, 1357. However, she chose not to attend to her Patient C, who was ultimately transferred to Madigan Medical Center and treated successfully there. CP 908. This incident prompted St. Joseph Medical Center (SJMC) to self-report a "potential EMTALA violation" to the Center for Medicare Services (CMS). CP 958. Subsequently, CMS investigated thoroughly and concluded that SJMC violated EMTALA and thus had to formulate a plan of corrective actions. CP 1384-5. CMS never charged or adjudicated a potential EMTALA violation against me. Based on that self-reporting letter to CMS, MQAC independently conducted an adjudicative hearing on this "potential EMTALA violation" claim from January 30th, 2018 to February 1st, 2017. CP 109. Concluding the hearing, Judge Dixon announced, "we try to get an order out within 45 to 90 days." CP 1857. On May 3rd, 2017, Judge Dixon *untimely* issued a post-hearing order No. 1 extending time to issue the final order to May 26th, 2017. CP 891. On October 2nd, 2017, I was *untimely* served with the Findings of Fact, Conclusions of Law, and Final Order (Final Order). CP 896. MQAC legally concluded that I violated EMTALA and cited 42 U.S.C § 1395dd(d)(1)(B). CP 910-1. Yet, there is no adjudicative record by CMS

or any federal agency with EMTALA subject matter jurisdiction concluding that I violated that statute. A petition for reconsideration by the AG Office was timely filed on October 11th, 2017 but was *untimely* disposed of on November 2nd, 2017. CP 918-30; RCW 34.05.470(3). My timely petition for judicial review with the Superior Court was accepted on October 30th, 2017. CP 1-3. The Amended Final Order was served on December 22nd, 2017. CP 934. After oral arguments for the judicial review, Superior Court Judge Helson issued her order on August 9th, 2018. CP 1994. I timely filed my Notice of Appeals on September 5th, 2018. CP 2001. After oral arguments, the COA filed its unpublished decision on August 19th, 2019. The COA denied my timely motion for consideration but granted my motion to publish on October 23rd, 2019. Appendix A.

No conviction, legal settlement, negligence or malpractice claim or judgement, or prior discipline exists in my personal and professional records. In fact, it is one of the mitigating factors considered by MQAC. CP 912-3 (COL 2.12).

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

This COA's published decision meets all four criteria for review by this Court per Rules of Appellate Procedure (RAP) 13.4(b).

A. This Decision Conflicts with Decisions of the Supreme Court and Published Decisions of the COA. RAP 13.4(b)(1) and (2).

1. This Court and COA have consistently held that as a matter of law, a tribunal must first find a duty of care to legally conclude that a physician commits "incompetence, negligence, or malpractice" and "practice[s] below the standard of care".

This case is a judicial review of the legal conclusions by MQAC that I committed "incompetence, negligence, or malpractice" for "my refusal to consult with fellow physicians and treat patients, while acting as an on-call specialist" and that my "conduct falls in Tier B of the Practice Below the Standard of Care schedule. WAC 246-16-810". COL 2.5, 2.6, and 2.12; CP 909-12. The COA concluded, "[t]he plain language of RCW 18.130.180(1) and (4) does not require MQAC to find a duty of care" (Decision 13) when no case law exists to exempt an administrative tribunal from this well-settled legal standard. Only case laws arising out of medical negligence and malpractice lawsuits exist. Accordingly, as a matter of law, MQAC must first find a doctor-patient relationship and thus a duty of care to make COL 2.5, 2.6, and 2.12. This published decision conflicts with binding decisions by the COA and this Court. Firstly, the Court of Appeals in Judy v. Hanford Envtl. Health Found., 106 Wn.App. 26, 39, 22 P.3d 810 (2001) affirms,

> "There can be no malpractice when there is not only no doctor-patient relationship, but no contact, no intent to diagnose, treat or otherwise benefit the patient, no injury directly caused by the examination, no failure to diagnose or notify the patient of an illness disclosed by the examination, and no dispute as to the accuracy of the reported results."

Secondly, in Khung Thi Lam v. Global Med. Sys., Inc., 127 Wash.App. 657, 664, 111 P.3d 1258 (2005), this COA itself has ruled,

> "As a preliminary matter, GMS makes several arguments to the effect that it owed no duty to Dang. We must resolve this question first, for if there is no duty, standard of care is irrelevant."

Finally, in Volk v. DeMeerleer, 187 Wn.2d 241, 254-5, 386 P.3d 254 (2016), the Supreme Court opines (emphasis added):

> "[M]edical malpractice imposes a **duty** on the medical professional to act consistently with the standards of the medical profession, and the **duty is owed to the medical professional's patient**. *See* Paetsch v. Spokane Dermatology Clinic, PS, 182 Wn.2d 842, 850, 348 P.3d 389 (2015). At common law, Washington does not recognize a cause of action for medical malpractice absent a physician/patient relationship. *See* Riste v. Gen. Elec. Co., 47 Wn.2d 680, 682, 289 P.2d 338 (1955)."

> "In Washington, "[t]he elements of negligence include the existence of a **duty** to the plaintiff, breach of that **duty**, and injury to the plaintiff proximately caused by the breach." Aba Sheikh, 156 Wn.2d at 447-48 (*citing* Degel v. Majestic Mobile Manor, Inc., 129 Wn.2d 43, 48, 914 P.2d 728 (1996))."

Like any tribunal, MQAC must abide by these well-settled legal standards to legally conclude that a physician committed "incompetence, negligence, or malpractice" and practiced "below the standard of care". This COA's decision exempts MQAC from these legal standards, conflicts with binding legal precedents, and should be reviewed by this Court.

2. Affirming the Amended Final Order, which violated the mandatory statutory time limits of RCW 34.05.461(8)(a), .470(3) and res judicata principle, conflicts with binding precedents by the Supreme Court and COA.

The COA holding that statutory time limits of RCW 34.05.470(3) and .461(8)(a) are directory in affirming MQAC's Amended Final Order (Decision 19-21) conflicts with well-settled legal precedents and statutory construction principles.

First, "the designation of time" in RCW 34.05.470(3) plainly and unambiguously limits "the power of the officer". Niichel v. Lancaster, 97 Wn.2d 620, 623, 647 P.2d 1021 (1982). After the 20-day statutory limit, the presiding officer cannot "dispose of" or "act on" the petition for reconsideration because such a petition is deemed "denied". RCW 34.05.470(3). At such time, the **Final** Order was subject to res judicata. Columbia Rentals, Inc. v. State, 89 Wn.2d 819, 821, 576 P.2d 62 (1978) (final judgment is res judicata); *see also* Lejeune v. Clallam Cy., 64 Wn.App. 257, 265, 823 P.2d 1144, *review denied*, 119 Wn.2d 1005 (1992) (Res judicata applies to quasi-judicial administrative decisions). MQAC violated res judicata by amending its Final Order outside the appellate process. St. Joseph Hosp. v. Dep't of Health, 125 Wn.2d 733, 744, 887 P.2d 891 (1995). On October 30th, 2017, my petition for judicial review started the appellate process in the Superior Court. MQAC cannot "change its final judgement while an appeal is pending, *see* RAP 7.2(a), except when the tribunal is otherwise authorized to do so and certain other conditions are met. *See* RAP 7.2(e)" because MQAC "lack[s] inherent

power to reconsider its own res judicata decisions". Lejeune v. Clallam Cy., 64 Wn.App. at 266-70. This comports with Diehl v. Growth Mgmt. Hearings Bd., 153 Wn.2d 207, 216, 103 P.3d 193 (2004), which held that "it was more appropriate to look to the rules of appellate procedure" in reviewing administrative appeals "given the appellate jurisdiction of the trial court under the APA". As such, the COA erred in affirming the Amended Final Order, which is unlawful.

Second, the Decision conflicts with Supreme Court decision holding,

> "It is impossible to substantially comply with a statutory time limit… It is either complied with or it is not. Service after the time limit cannot be considered to have been actual service within the time limit." Seattle v. PERC, 116 Wn.2d 923, 928, 809 P.2d 1377 (1991).

Additionally, the COA itself opined,

> "If an attempt to file five minutes late can be construed as timely, we see no reason why an attempt to file five hours late or in fact at any time before midnight should not be similarly construed. There would be no difference in the legal principle presented but obviously such a holding would border on the absurd." San Juan Fidalgo Holding Co. v. Skagit County, 87 Wn. App. 703, 713, 943 P.2d 341 (1997), *review denied*, 135 Wn.2d 1008, 959 P.2d 127 (1998).

Third, the Decision conflicts with this Court's decisions holding,

> "When statutes impose duties upon public officers, if the provisions affect the public interest, or are intended to protect a private citizen against loss or injury to his property, they are held to be mandatory rather than directory." *See, e.g.*, Spokane County ex rel. Sullivan v. Glover, 2 Wn.2d 162, 97 P.2d 628 (1940); Faunce v. Carter, 26 Wn.2d 211, 173 P.2d 526 (1946); State ex rel. Billington v. Sinclair, 28 Wn.2d 575, 183 P.2d 813 (1947); Niichel v. Lancaster, 97 Wn.2d 620, 647 P.2d 1021 (1982).

Fourth, the Decision conflicts with this Court's general rule in statutory construction:

> "The use of the word "shall" in a statute is imperative and operates to create a duty rather than to confer discretion." Clark Cy. Sheriff v. Department of Social & Health Servs., 95 Wn.2d 445, 448, 626 P.2d 6 (1981); *see e.g.*, State v. Bartholomew, 104 Wash.2d 844, 848, 710 P.2d 196 (1985); Spokane County ex rel. Sullivan v. Glover, 2 Wn.2d 162, 169, 97 P.2d 628 (1940).

Additionally, "the legislature intended the two words to have different meanings, with "shall" being imperative" when the words "may" and "shall" are used in RCW 34.05.461(8)(a). State v. Blazina, 182 Wn.2d 827, 838, 344 P.3d 680 (2015); s*ee also*, Erection Co. v. Department of Labor Indus., 121 Wn.2d 513, 519, 852 P.2d 288 (1993). As such, it is "imperative" and mandatory for MQAC to serve its final order within 90 days after the hearing. *See* RCW 34.05.461(8)(a). "A mandatory provision in a statute is one which, if not followed, renders the proceeding to which it relates illegal and void." Spokane County ex rel. Sullivan v. Glover, 2 Wn.2d 162, 169, 97 P.2d 628 (1940).

Finally, the Decision nullifies duly enacted statutory time limits of the WA Administrative Procedure Act. A court will not construe a statute in a manner that would thwart the clear intent of the statutory language. San Juan Fidalgo Holding Co. v. Skagit County, 87 Wn. App. 703, 710, 943 P.2d 341 (1997), *review denied*, 135 Wn.2d 1008, 959 P.2d 127 (1998).

The legislative history of RCW 34.05.470 shows a change of the deadline for reconsideration from discretionary to mandatory in 1989. http://leg.wa.gov/CodeReviser/documents/sessionlaw/1989c175.pdf?cite=1989%20c%20175%20%C2%A7%2021; at Sec. 21 on page 787 (App. C). The Legislature eliminated the agency head's discretion to extend the time limit to act on a petition for reconsideration.

3. The COA decision that MQAC has the authority to interpret, adjudicate, and enforce EMTALA is in conflict with the Supreme Court decision that an administrative agency only has such authorities as granted by the legislature.

The COA erred to interpret a definition of unprofessional conduct, RCW 18.130.180(7), as an expansive authority to interpret and enforce "any federal statute" regulating medicine, including EMTALA. Such interpretation is beyond the plain language of RCW 18.130.050.

An administrative agency like MQAC is created by statute and "as such has no inherent powers, but only such as have been expressly granted to it by the legislature or have, by implication, been conferred upon it as necessarily incident to the exercise of those powers expressly granted." State ex rel. Pub. Util. Dist. No. 1 of Okanogan County v. Dep't of Pub. Serv., 21 Wn.2d 201, 208-9, 150 P.2d 709 (1944). MQAC has no statutory authority to interpret, adjudicate, and enforce EMTALA per 42 U.S.C §1320a–7a and RCW 18.130.050. If an enabling statute, EMTALA in this

case, does not explicitly or implicitly authorize MQAC to interpret, adjudicate, and enforce EMTALA, "that regulation must be declared invalid despite its practical necessity or appropriateness." Wash. Indep. Tel. Ass'n v. Telecomm. Ratepayers Ass'n for Cost-Based Equitable Rates, 75 Wn. App. 356, 363, 880 P.2d 50 (1994). The COA in this case must "not defer to an agency the power to determine the scope of its own authority." In re Elec. Lightwave, Inc., 123 Wn.2d 530, 540, 869 P.2d 1045 (1994). RCW 18.130.180(7) is a mere definition, not authorization.

B. This Decision Raises Significant Questions of Law Under the State and US Constitutions. RAP 13.4 (b)(3).

1. Whether MQAC is pre-empted from concurrent jurisdiction over EMTALA, a statute with exclusive federal jurisdiction; If so, whether RCW 18.130.180(7) supersedes the Supremacy Clause of the US Constitution and its well-established jurisprudence.

The nexus for this case is a “potential EMTALA violation” claim reported by SJMC to CMS, the agency in the US Department of Health and Human Services with exclusive jurisdiction over EMTALA. CP 958. Congress enacted EMTALA with an explicit intent to make its jurisdiction exclusively federal. 42 U.S.C § 1395dd(d)(1). EMTALA is only for the Secretary of the US DHHS to interpret, adjudicate, and enforce according to 42 U.S.C §1320a–7a(c) and the US Court of Appeals to review his or her adverse decision per §1320a–7a(e). Accordingly, MQAC, a state

agency, is pre-empted from concurrent subject matter jurisdiction over EMTALA to independently adjudicate a claim and then conclude that I violated EMTALA to enforce a civil money penalty. CP 911. Generally, states may only assume subject-matter jurisdiction over a federal cause of action absent provision by Congress to the contrary. Gulf Offshore Co. v. Mobil Oil Corp., 453 U.S. 473, 477-8, 101 S.Ct. 2870, 2875, 69 L.Ed.2d 784 (1981); Rice v. Janovich, 109 Wn.2d 48, 51-2, 742 P.2d 1230 (1987). Also, "the presumption of concurrent jurisdiction can be rebutted by an explicit statutory directive" like 42 U.S.C §1395dd(d)(1)(B) and §1320a–7a. *Id*. "It is clearly within Congress' powers to establish an exclusive federal forum [whether administrative or judicial] to adjudicate issues of federal law in a particular area that Congress has the authority to regulate under the Constitution". Longshoremen v. Davis, 476 U.S. 380, 388, 106 S. Ct. 1904 (1986) (*citing* Kalb v. Feuerstein, 308 U.S. 433 (1940)).

> "Enactment of such exclusive jurisdiction must, by operation of the Supremacy Clause, pre-empt conflicting state-court jurisdiction. That the entity chosen to administer those laws is administrative rather than judicial, as in *Kalb*, does not alter the pre-emptive effect of the federal law." *Id* at 394 (footnote 11).

On the contrary, RCW18.130.180(7) is a mere catch-all nonspecific definition of an unprofessional conduct and not an explicit statutory authorization by the WA State Legislature for MQAC to independently interpret and enforce EMTALA. The COA held that RCW18.130.180(7)

authorizes MQAC to adjudicate a claim of a violation of any "federal statue" [sic] … regulating medical profession, including EMTALA. Decision at 16. Such an overbroad interpretation of RCW18.130.180(7) is incompatible with the US Constitution. Granting MQAC the concurrent jurisdiction to adjudicate and enforce a EMTALA claim beyond the plain and unambiguous language of 42 U.S.C §1395dd(d)(1)(B) and §1320a–7a(c) conflicts with the Supremacy Clause of the US Constitution and its precedents. *See also* COA Reply Brief 16-18. Even if the WA Legislature had enacted a state version of EMTALA, such state version must not "directly conflicts with a requirement of this section". 42 U.S.C. § 1395dd(f). Recognizing the compelling state interest in regulating the practice of professions as stated in Goldfarb v. Virginia State Bar, 421 U. S. 773, 792 (1975), the Supreme Court in Gade v. National Solid Waste Management Association, 505 U.S. 88, 108, 112 S. Ct. 2374 (1992) clarified the pre-emption doctrine,

> "A state law also is pre-empted if it interferes with the methods by which the federal statute was designed to reach th[at] goal". *Id* at 103.
>
> "'[A]ny state law, however clearly within a State's acknowledged power, which interferes with or is contrary to federal law, must yield.'" Felder v. Casey, 487 U. S., at 138 (quoting Free v. Bland, 369 U. S. 663, 666 (1962)); *see also* De Canas v. Bica, 424 U. S. 351, 357 (1976) ("[E]ven state regulation designed to protect vital state interests must give way to paramount federal legislation")." *Id* at 108.

Here, a mere catch-all definition of an unprofessional conduct, RCW 18.130.180(7), is not a state version of EMTALA. Even so, it frustrates Congressional intent to enact EMTALA with exclusive federal jurisdiction and interferes with the US DHHS statutory authority as the sole and primary adjudicator of EMTALA violations, subject to judicial review by the US Court of Appeals as clearly enacted in 42 U.S.C §1320a–7a. State agencies and courts must yield to the "unambiguously expressed intent of Congress". Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-3, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). RCW 18.130.180(7) cannot supersede this duly enacted federal law excluding state concurrent jurisdiction over EMTALA.

MQAC argued that I waived this issue on appeal even though this issue was raised and "argued" in my prehearing statement. CP 309-11; *see also* Decision 15. A 2-page argument on this issue "must be more than simply a hint or a slight reference to the issue in the record" in order for this issue to be "properly raised before" MQAC. King County v. Boundary Review Bd. for King County,122 Wn.2d 648, 670, 860 P.2d 1024 (1993). This Court in King County, *supra*, as well as the COA in Kitsap Alliance v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd.,160 Wn. App. 250, 271-2, 255 P.3d 696 (2011) did not go so far as mandating that "An appellant must do more than raise the issue below" to preserve it for

appeal. Decision 16. Yet, the COA went on to rule on this "waived" issue. Even if this Court considers a 2-page long argument not adequate to preserve this issue, precedents and court rules for raising the issue of jurisdiction for the first time on appeal exist. Maynard Inv. Co., Inc. v. McCann, 77 Wn.2d 616, 621, 465 P.2d 657 (1970).

> "The ordinary rule that errors not raised below will not be considered on appeal has been treated as subject to an exception where the matter raised for the first time on appeal was of such a character as to render the judgment of the lower court void, as where the court had **no jurisdiction of the subject matter**." *Id* at 621.

> "Courts are created to ascertain the facts in a controversy and to determine the rights of the parties according to justice. Courts should not be confined by the issues framed or theories advanced by the parties if the parties ignore the mandate of a statute or an established precedent." *Id* at 623.

"The text of RAP 2.5(a) clearly delineates three exceptions that allow an appeal as a matter of right." State v Blazina, 182 Wn.2d at 833. As such, even for the first time on appeal, court rules and precedents allowed me to raise the issue that MQAC lacks EMTALA subject matter jurisdiction.

2. Whether RCW 18.130.180(1) and (4) prohibit a physician from exercising his or her speech and independent medical opinion.

MQAC concluded that I violated RCW 18.130.180(1) and (4) for my "refusal to aid and consult with fellow physicians, while acting as an on-call specialist, constitutes acts of moral turpitude and lowers the standing of the profession in the eyes of the public" (COL 2.3 and 2.4) and that my

"refusal to consult with fellow physicians and treat patients, while acting as an on-call specialist, created an unreasonable risk of patient harm" (COL 2.5 and 2.6). Yet, no provision in the UDA mandates an on-call specialist to automatically enter into a professional relationship with and render his or her services to ER physicians and patients without his or her consent or consideration for his or her capabilities. The UDA, chapter 18.130 RCW, does not prohibit an on-call physician from exercising his or her speech and independent medical judgment in deciding whom to consult or treat, especially when that physician was physically incapable and did not feel competent to take care of a particular patient.

3. Whether it is a violation of the Due Process Clause of the US Constitution and the Washington Constitution Art. 1, § 10 for MQAC to serve and amend its Final Order beyond the statutory time limits of RCW 34.05.470(3) and .461(8)(a).

""Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment." Mathews v. Eldridge, 424 U.S. 319, 332, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976). A medical license is a constitutionally protected property interest which must be afforded due process." Nguyen v. Department of Health Medical Quality Assurance Commission, 144 Wn.2d 516, 523, 29 P.3d 689 (2001). A physician's license, professional

standing and reputation, and ability to earn a living are "much more important" interests than a money fine alone. *Id* at 526. "The more important the interest, the less tolerant we are as a civilized society that it be erroneously deprived." *Id* at 524. And thus, the more procedural due process is required. *Id* at 525. There is a public policy in maintaining the interests of individuals as well as one in upholding the agencies of government. *Id* at 525. As such, MQAC must strictly honor the mandatory statutory time limits of RCW 34.05.470(3) and .461(8)(a) to protect both private and governmental interests.

Furthermore, this Court held in State v. Young, 125 Wn.2d 688, 696, 888 P.2d 142 (1995),

> "We will not interpret a statute "so as to render any portion meaningless, superfluous or questionable". Addleman v. Board of Prison Terms Paroles, 107 Wn.2d 503, 509, 730 P.2d 1327 (1986)…. A statute must be read as a whole giving effect to all of the language used. Alderwood Water Dist. v. Pope Talbot, Inc., 62 Wn.2d 319, 321, 382 P.2d 639 (1963). *See also* State v. S.P., 110 Wn.2d 886, 890, 756 P.2d 1315 (1988). "Each provision must be viewed in relation to other provisions and harmonized if at all possible to insure proper construction of every provision." Addleman, at 509."

Accordingly, the statutory time limits of RCW 34.05.461(8)(a) and .470(3) together are intended to forestall any "unnecessary delay" by MQAC and to protect the accused physician's constitutional right to a timely judicial review of MQAC adverse actions. Washington Constitution Art. 1, § 10. My constitutional right to a timely judicial

review of MQAC's adverse action cannot be initiated without the timely service of its Final Order. RCW 34.05.542(2). Thus, the statutory time limits of RCW 34.05.461(8)(a) and .470(3) are statutorily and constitutionally mandatory and must be complied with.

C. This Decision Involves Issues of Public Interest That Should Be Determined by the Supreme Court. RAP 13.4 (b)(4).

1. In the interest of justice and public safety, MQAC must obey its own governing laws and procedural due process.

MQAC must be compelled to follow strict statutory time limits to protect the public's health and safety because the law is clear:

> "Safeguarding the public's health and safety is the paramount responsibility of" MQAC. RCW 18.130.160.
>
> "It is the purpose of the commission to regulate the competency and quality of professional health care providers under its jurisdiction." RCW 18.71.002.
>
> "These rules establish basic time periods for processing and resolving complaints against credentialed health care providers and applicants. The rules also provide enforcement mechanisms to ensure timely disposition of complaints and adjudicative proceedings. The department of health does not anticipate that the basic time period will be used in all cases. These rules are adopted as required by RCW 18.130.095(1). The intent is to promote **timely protection of the public** and **fairness** to credential holders, applicants, and complainants, without sacrificing public safety." WAC 246-14-010 (emphasis added).

Exempting MQAC from mandatory statutory time limits as erroneously ruled by the COA did not serve the public interest in ensuring "the competency and quality of physicians" and "safeguarding the public's

health and safety" from incompetent and dangerous healthcare providers. MQAC's disregard of statutory time limits of RCW 34.05.461(8)(a) and .470(3) does not promote fairness to an accused physician.

2. The Public is best served when physicians have autonomy in medical decision-making and free speech.

"Reasonable latitude must … be allowed the physician in a particular case; and we would not lay down any rule which would unreasonably interfere with the exercise of his discretion, or prevent him from taking such measures as his judgment dictated for the welfare of the patient in a case of emergency." Rolater v. Strain, 39 Okla. 572, 577-8, 137 P. 96 (1913), *citing* Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).

This COA ruling that MQAC is not required to establish a duty of care as a matter of law before legally concluding that a physician committed "incompetence, negligence, or malpractice" and practiced "below the standard of care" has startling implications and profound public interest. If on-call specialists must render their services to anyone without regard for their own independent medical judgment and capacity or risk being sanctioned by MQAC for exercising their speech and medical judgment, few specialists will offer to be on call to serve the emergent needs of WA residents. "The public is ultimately dependent upon the provision of a physician's services, not their elimination." Nguyen, 144 Wn.2d at 533.

3. Public confidence in the impartial administration of equal justice under law is eroded by this COA Decision.

Public confidence in the judiciary is weakened when the "citizenry concludes, even erroneously, that cases are decided on the basis of favoritism or prejudice rather than according to law and fact". Discipline of Niemi, 117 Wn.2d 817, 824, 820 P.2d 41 (1991). A pro se litigant must obey every statutory deadline to preserve his interest and rights. However, the COA declined to hold MQAC to account for its violations of RCW 34.05.461(8)(a) in issuing its Final Order and of RCW 34.05.470(3) and res judicata principle in issuing its Amended Final Order. This biased and unprecedented application of the law creates an appearance of "favoritism" toward MQAC and of unfairness against a pro se appellant. MQAC is not above the law and cannot defy statutory time limits and res judicata principle with impunity. "Res judicata rests upon public policy considerations which favor certainty in the establishment of legal relations, demand an end to litigation, and seek to prevent the harassment of parties." Bates v. Devers, 214 Va. 667, 670, 202 S.E.2d 917, 920 (1974) (citations omitted).

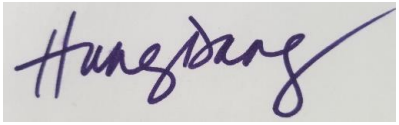
It was not MQAC's total disregard for RCW 34.05 and 18.130 and binding legal principles itself that was such a dark stain on the rule of law; it was the fact that the Office of Attorney General defended vigorously

such lawlessness and the lower courts legalized it. Granting this petition for review by this Court will help restore public confidence.

VI. CONCLUSION

MQAC's Amended Final Order should never be affirmed because it is legally untenable and procedurally flawed to be compatible with the US and WA Constitutions and binding precedents. I urge this Court to accept this petition and reverse the COA decision to restore law and order. I fled the tyranny, lawlessness, and corruption of communist Vietnam with my family in 1992 to pursue the American dream. I embrace the American ideals of democracy, freedom, justice, opportunity, and equality. The Commission's egregious power grab and insolent lawlessness have shaken my belief in the American ideals to the core, particularly that of "Equal Justice Under Law". Only this Court can ever restore my confidence in government and the impartiality and independence of the Judiciary.

Respectfully submitted on November 21st, 2019,



HUNG DANG, MD

CERTIFICATE OF SERVICE BY MAIL

I certify that I served a copy of the foregoing Petition for Review to the following parties by first class mail or email:

1. Christina Pflueger WSBA #44231 christina.pfluger@atg.wa.gov; julie.feser@atg.wa.gov, and
   Debra Defreyn WSBA# 28317 debrad@atg.wa.gov; diane.graf@atg.wa.gov
   1125 Washington Street SE
   Olympia, WA 98504-0100
   Atty. For: Respondent
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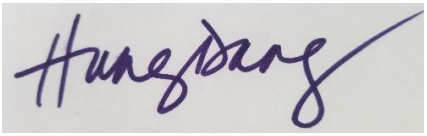
2. WA State Medical Quality Assurance Commission
   c/o Rick Glein, staff attorney at

   111 Israel Rd. S.E.
   Tumwater, WA 98501

   Postage has been prepaid, on November 21st, 2019.



Hung H. Dang, M.D.

Pro se Appellant

Appendix A

FILED
10/23/2019
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

HUNG DANG, M.D., Appellant, v. Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION, Respondent.	No. 78910-4-I ORDER DENYING MOTION FOR RECONSIDERATION

Appellant Dr. Hung Dang filed a motion for reconsideration of the opinion filed on August 19, 2019. Respondent Washington State Department of Health Medical Quality Assurance Commission filed an answer to the motion. A majority of the panel has determined that the motion should be denied. Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

FOR THE COURT:

Judge

FILED
10/23/2019
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

HUNG DANG, M.D., Appellant, v. Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION, Respondent.	)	No. 78910-4-I ORDER GRANTING MOTION TO PUBLISH

Appellant Dr. Hung Dang filed a motion to publish the opinion filed on August 19, 2019. Respondent Washington State Department of Health Medical Quality Assurance Commission filed an answer to the motion. A majority of the panel has determined that the motion should be granted. Now, therefore, it is hereby

ORDERED that appellant's motion to publish the opinion is granted.

FOR THE COURT:

Judge

FILED
8/19/2019
Court of Appeals
Division I
State of Washington

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

HUNG DANG, M.D., Appellant, v. Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION, Respondent.	)	No. 78910-4-I UNPUBLISHED OPINION FILED: August 19, 2019

SCHINDLER, J. — Hung Dang, MD appeals the superior court order affirming the decision of the Washington State Department of Health Medical Quality Assurance Commission (MQAC). MQAC concluded Dr. Dang committed unprofessional conduct in violation of the Uniform Disciplinary Act, chapter 18.130 RCW; ordered oversight of his license; and imposed at $5,000 fine. We affirm the amended MQAC decision and final order.

On Call at St. Joseph Medical Center

Dr. Hung Dang is an otolaryngologist, specializing in the treatment of the ear, nose, and throat (ENT). Dr. Dang works at Group Health Cooperative[1] in Tacoma. As

[1] We note Kaiser Permanente acquired Group Health in 2017. We use "Group Health" throughout the opinion.

a condition of his employment with Group Health, Dr. Dang maintains staff privileges and works as an on-call emergency ENT specialist at St. Joseph Medical Center in Tacoma. St. Joseph is one of several hospitals in the CHI Franciscan Health System and is a level II trauma center. The CHI Franciscan Health System is a nonprofit corporation dedicated to providing healthcare consistent with Catholic Health Initiatives. The other hospitals include St. Francis Hospital in Federal Way, St. Clare Hospital in Lakewood, St. Anthony Hospital in Gig Harbor, and St. Elizabeth Hospital in Enumclaw.

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, requires hospitals to treat patients that need emergency care. The purpose of EMTALA is to ensure that individuals receive adequate emergency medical care regardless of ability to pay. Jackson v. E. Bay Hosp., 246 F.3d 1248, 1254 (9th Cir. 2001). Under EMTALA, a hospital must provide appropriate emergency medical care or transfer the patient to another medical facility. 42 U.S.C. § 1395dd(b)(1).

An on-call physician may not refuse to provide medical care and treat a patient properly transferred by an emergency room (ER) physician. 42 U.S.C. § 1395dd(d)(1)(B). Under 42 U.S.C. § 1395dd(d)(1)(B), a physician "is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on call for the care of such an individual." A hospital that can provide specialized care may not refuse to accept an appropriate transfer from a referring hospital if the receiving hospital has the capacity to treat the patient. 42 U.S.C. § 1395dd(g), (c)(2)(B). A transfer to a medical facility is appropriate if "the transferring hospital provides the medical treatment within its capacity which minimizes the risks to

the individual's health," the receiving facility "has available space and qualified personnel for the treatment of the individual," and the receiving facility "has agreed to accept transfer of the individual and to provide appropriate medical treatment." 42 U.S.C. § 1395dd(c)(2)(A), (B).

Statewide Emergency Medical Trauma Care Centers

In 1990, the Washington State Legislature enacted the Statewide Emergency Medical Services and Trauma Care System Act (EMSTCSA), chapter 70.168 RCW, "to establish an efficient and well-coordinated statewide emergency medical services and trauma care system." LAWS OF 1990, ch. 269; RCW 70.168.010(3). The legislature states the intent of EMSTCSA is to "reduce costs and incidence of inappropriate and inadequate trauma care and emergency medical service and minimize the human suffering and costs associated with preventable mortality and morbidity." RCW 70.168.010(3). The objective of EMSTCSA is to "(a) [p]ursue trauma prevention activities to decrease the incidence of trauma; (b) provide optimal care for the trauma victim; (c) prevent unnecessary death and disability from trauma and emergency illness; and (d) contain costs of trauma care and trauma system implementation." RCW 70.168.010(4).

EMSTCSA requires the Washington State Department of Health to designate trauma care services at hospitals. RCW 70.168.015(5). EMSTCSA categorizes hospitals into one of five levels of care. RCW 70.168.015(4). EMSTCSA designates the level of trauma care services at each hospital as level I to level V, the highest level of trauma care to the lowest level of trauma care. RCW 70.168.015(4), (15), (23). Lower level designated trauma centers can transfer patients to high-level hospitals for

care and treatment by a specialist. RCW 70.168.015(23); WAC 246-976-700(8), (9). Designated trauma service care hospitals must provide emergency and trauma services to all patients requiring care without regard to ability to pay. RCW 70.168.130(3)(b).

Uniform Disciplinary Act

The Uniform Disciplinary Act (UDA), chapter 18.130 RCW, governs licensing and discipline of physicians. The purpose of the UDA is (1) to protect the public and (2) to protect the standing of the medical profession in the eyes of the public. In re the Revocation of the License To Practice Medicine & Surgery of Kindschi, 52 Wn.2d 8, 11, 319 P.2d 824 (1958). The UDA gives the Washington State Department of Health Medical Quality Assurance Commission (MQAC)[2] the authority to regulate, monitor, and discipline physicians. RCW 18.30.040(2)(b)(ix); chapter 18.71 RCW; chapter 18.71A RCW.

Statement of Charges

On April 4, 2016, the Washington State Department of Health Medical Program (Department of Health) filed a statement of charges against Dr. Dang, alleging violation of EMTALA and RCW 18.130.180(1), (4), and (7) with respect to "Patient A," "Patient B," and "Patient C." RCW 18.130.180, "Unprofessional Conduct," provides, in pertinent part:

> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. . . .
>
> . . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. . . .
>
> . . . .

[2] In July 2019 (LAWS OF 2019, ch. 55, § 7), MQAC became the "Washington Medical Commission."

> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.[3]

Patient A

On October 20, 2012, 61-year-old Patient A went to the ER at St. Clare Hospital. St. Clare is a level IV trauma center. Patient A had a history of thyroid cancer and undergone prior neck surgery. On October 20, Patient A had "facial swelling, an enlarged tongue with airway obstruction, and difficulty with breathing and swallowing." A CT[4] scan showed

> bilateral lymph node dissection of the neck, enlargement of the base of the tongue with contiguous abnormal soft tissue swelling of the left oral floor and left lateral wall of the oral cavity, possibly representing a recurrent squamous cell carcinoma or an infectious or inflammatory process.

St. Clare did not have an on-call ENT doctor. The ER doctor concluded Patient A needed a higher level of care from an ENT specialist. The ER doctor contacted Dr. Dang at St. Joseph to request transfer of Patient A. Dr. Dang refused to accept the transfer of Patient A because he was not on call for St. Clare but consulted with the ER doctor and said the patient could "follow up with the clinic on Monday."

Because of "the dangerous nature of Patient A's possible airway obstruction," the St. Clare ER doctor believed "a more urgent consult" was necessary and transferred Patient A to Harborview Medical Center, a level I trauma center. Harborview accepted the transfer. St. Clare airlifted Patient A to Harborview. An ENT specialist diagnosed Patient A with "acute angioedema" and admitted Patient A to intensive care.

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[3] The legislature amended RCW 18.130.180 several times after 2016. LAWS OF 2018, ch. 216, § 2; LAWS OF 2018, ch. 300, § 4; LAWS OF 2019, ch. 427, § 17. The amendments do not change the language pertinent to our analysis.

[4] Computed tomography.

Patient B

On November 23, 2013, 34-year-old Patient B went to the ER at St. Francis Hospital for "sore throat, swelling, and difficulties with swallowing and breathing." St. Francis is a level IV trauma center. A CT neck scan "showed fluid collection and findings consistent with tonsillar abscess." The ER doctor concluded Patient B should be transferred to St. Joseph for consultation and treatment by an ENT specialist. St. Francis staff contacted St. Joseph on-call ENT specialist Dr. Dang to request the transfer. Dr. Dang refused to consult or accept the transfer.

Patient C

On June 8, 2014, 24-year-old Patient C went to the ER at St. Clare. Patient C had pain in his ear and throat and trouble swallowing. The ER doctor diagnosed Patient C with a tonsillar abscess and a potential "life-threatening" airway obstruction.

> Patient C was diagnosed with tonsillar abscess (a collection of pus behind the tonsils that involves pain, swelling, and often radiates into the ear) with mild airway obstruction. The treating staff suspected a retropharyngeal abscess (deep neck space infections that can pose an immediate life-threatening emergency with potential for airway compromise).

The ER doctor contacted St. Joseph on-call ENT specialist Dr. Dang to request a transfer for treatment. Dr. Dang refused to consult or accept transfer of Patient C because he was not on call for St. Clare.

The St. Clare ER doctor contacted Harborview. After learning Harborview did not have the capacity to accept transfer of Patient C, the St. Clare ER doctor called CHI Franciscan Associate Chief Medical Officer Dr. Kim Moore. Dr. Moore authorized transfer of Patient C from St. Clare to St. Joseph for consultation and treatment by the on-call ENT doctor.

When Patient C arrived at St. Joseph, Dr. Dang refused to consult or treat Patient C. Dr. Moore contacted Dr. Dang. Dr. Dang told Dr. Moore he would not treat Patient C. Six hours later, Dr. Moore transferred Patient C to Madigan Army Medical Center for treatment. Madigan is a level II trauma center.

Administrative Hearing

Dr. Dang retained an attorney and filed an answer to the statement of charges. Dr. Dang denied the allegations that he violated EMTALA or RCW 18.130.180(1), (4), and (7). Dr. Dang requested a hearing.

The three-day MQAC hearing began on January 30, 2017. The Department of Health called Dr. Dang; Dr. Moore; expert witness Warren Appleton, MD, JD; and St. Francis ER doctor Sarah Sliva to testify. Dr. Dang called expert witnesses Robert Bitterman, MD, JD and Dr. Alan Pokorny and his practice partner Dr. Alex Moreano to testify. The presiding chief health law judge admitted a number of exhibits into evidence, including the Franciscan Health System (FHS) medical records for Patients A, B, and C; the 2012 FHS bylaws; and orthopedic surgery records for Dr. Dang.

Dr. Dang testified he was acting as an on-call doctor only for St. Joseph. Dr. Dang testified he agreed to consult on Patient A. Dr. Dang asserted he did not refuse to consult on Patient B. Dr. Dang testified that he did not refuse to accept the transfer of Patient C. Dr. Dang said he told Dr. Moore that he was "not physically capable" of treating Patient C. Dr. Dang testified that in late February or early March 2014, he had ankle surgery. Dr. Dang said that he fell and injured his heel on June 8, 2014 and took a "hydrocodone and acetaminophen combination . . . pill" for the pain.

Dr. Moore testified that she approved the transfer of Patient C from the St. Clare ER to St. Joseph's ER. Dr. Moore said Dr. Dang "refused to come in and see the patient." Dr. Moore called Dr. Dang and "asked him to go in and see the patient as the on-call ear, nose and throat doctor." Dr. Dang told Dr. Moore he "would not go in to see the patient because the patient had come from St. Clare." Dr. Moore testified that Dr. Dang did not give "any other reason why he would not or could not come in and see the patient."

Dr. Moore testified Dr. Dang had a duty to come to the St. Joseph ER on June 8, 2014 to consult and treat Patient C. Dr. Moore said that "when a request is made for consult," the FHS bylaws state the "consultant must appear as - as reasonably as patient's needs dictate and if they are unable to care for the patient, then that physician needs to assist to find someone else who can." If the on-call doctor is unavailable, "the physician should try to find coverage or backup" and let the emergency department "know that there is a crisis" and that the physician is "not going to be available for call so if a patient presents that needs their services, they can start to look outside of that hospital." Dr. Moore testified Dr. Dang "did not tell me that he was unable to perform his [on-]call duties."

Expert witness Dr. Appleton testified that in his opinion, Dr. Dang violated the professional conduct of licensed health care providers under RCW 18.130.180 and EMTALA. Dr. Appleton testified that because of the dangerous nature of the airway obstruction, the ER doctor could not discharge Patient A and follow the advice of Dr. Dang to wait until the following Monday. Dr. Appleton testified Dr. Dang violated the standard of care by refusing to consult and admit Patient B to St. Joseph. Dr. Appleton

testified the condition of tonsillar abscess of Patient B was an emergency that required immediate treatment by an ENT specialist. Dr. Appleton testified the tonsillar abscess of Patient C was an unstable medical emergency condition and the refusal of Dr. Dang to consult and admit the patient violated the standard of care and EMTALA.

Dr. Dang's expert witnesses Dr. Bitterman and Dr. Pokorny testified that Dr. Dang did not violate the standard of care or EMTALA.

Dr. Moreano is an ENT surgeon and practice partner with Dr. Dang at Group Health in Tacoma. Dr. Moreano testified Group Health affiliated with St. Joseph in Tacoma. Dr. Moreano said that as the on-call ENT specialist at St. Joseph, he regularly receives calls from the ER doctor at St. Clare and St. Francis to consult. Dr. Moreano testified that he and the other two members of the Group Health ENT practice group, Dr. Dang and Dr. Ken Deem, "decided" to tell the ER doctors from the other FHS hospitals that "by the bylaws of the [FHS] system we were not obligated to get involved in - in the care of those patients." However, Dr. Moreano conceded, "We were told by our own [Group Health] leadership that we must comply with their request that we manage the patients from their entire system."

MQAC Decision and Order

On September 29, 2017, MQAC issued a 22-page decision, "Findings of Fact, Conclusions of Law, and Final Order." The MQAC decision sets forth extensive findings of fact that address FHS, EMTALA, statewide emergency medical trauma centers, and the emergency medical conditions of Patients A, B, and C. MQAC made a number of credibility findings. MQAC expressly found Dr. Dang's testimony that he did not refuse to consult on Patient B and that he was unable to treat Patient C not credible. MQAC

found Dr. Appleton's expert testimony that Dr. Dang violated RCW 18.130.180 and EMTALA more credible than the expert witnesses who testified on behalf of Dr. Dang.

MQAC found FHS has a procedure to transfer patients.

> FHS has a Patient Placement Center, which may be used to organize or facilitate an orderly patient intake/transfer process. However, use of a Patient Placement Center does not preclude 'doctor to doctor' consults or transfer requests. Further, practitioners are not required by FHS to use the transfer/placement center. Moreover, failure to utilize a Patient Placement Center does not relieve a practitioner from his/her obligations under the Emergency Treatment and Active Labor Act.[5]

With respect to Patient A, MQAC concluded Dr. Dang did not violate RCW 18.130.180 or EMTALA. Specifically, MQAC found that with respect to Patient A, Dr. Dang "was not on-call" at St. Clare Hospital but consulted with the St. Clare ER doctor and suggested Patient A follow up with the clinic two days later.

MQAC concluded there was "insufficient evidence to find that the Respondent violated EMTALA with regard to Patient B." But MQAC concluded Dr. Dang violated RCW 18.130.180:

> [T]he Respondent's refusal to consult with the emergency room doctor concerning the care of Patient B lowered the standing of the profession in the eyes of the public. In addition, the Respondent's refusal to consult with a fellow physician, acting in good faith to help a patient, created an unreasonable risk of harm to Patient B.

With respect to Patient C, MQAC concluded Dr. Dang violated EMTALA and RCW 18.130.180:

> Patient C was experiencing an emergency medical condition, which had not been stabilized, and his transfer to [St. Joseph] was appropriate. As such, the Respondent violated EMTALA when he failed to treat Patient C, while on call for [St. Joseph]. However, assuming arguendo that the transfer was improper, the Respondent (as the on-call specialist), was nonetheless obligated under EMTALA to appear and treat Patient C once he was transferred to [St. Joseph]. In addition, the Respondent's failure to

[5] Footnotes omitted.

> identify a backup or to inform Dr. Moore (or [St. Joseph]) that he was unavailable at a time contemporaneous to the transfer, was inconsistent with Respondent's explanation. Lastly, the Respondent's refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public.

MQAC ordered oversight of Dr. Dang's medical license for two years and imposed monitoring requirements and a $5,000 fine.

Motion To Reconsider

On October 11, 2017, the Department of Health filed a motion for reconsideration to correct two scrivener's errors in the final order. Dr. Dang did not file a response or object. On December 20, 2017, MQAC issued "Amended Findings of Fact, Conclusions of Law, and Final Order" correcting the two scrivener's errors.

Superior Court Appeal

Dr. Dang filed a petition for judicial review in superior court. The superior court affirmed the amended MQAC final order but modified the monitoring period to begin May 26, 2017 instead of September 29, 2017. Dr. Dang appeals the superior court "Order on Petition for Judicial Review."

Standard of Review

The Washington Administrative Procedure Act (WAPA), chapter 34.05 RCW, governs judicial review of disciplinary proceedings under the UDA, chapter 18.130 RCW. On review, we sit in the same position as the superior court and apply the WAPA standards directly to the record before the agency. Tapper v. Emp't Sec. Dep't, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). As the party challenging MQAC's decision, Dr. Dang bears the burden of establishing the decision is invalid under one or more of the WAPA criteria. RCW 34.05.570(1)(a).

Under RCW 34.05.570(3), we will reverse only if (1) the administrative decision is based on an error of law, (2) the administrative decision is unsupported by substantial evidence, (3) the administrative decision is arbitrary or capricious, (4) the administrative decision violates the constitution, (5) the order is inconsistent with a rule of the agency, (6) the agency employed improper procedures, or (7) the order is outside the agency's statutory authority. Tapper, 122 Wn.2d at 402. We review conclusions of law de novo. Haley v. Med. Disciplinary Bd., 117 Wn.2d 720, 730, 818 P.2d 1062 (1991). However, we give due deference to the expertise and knowledge of MQAC and substantial weight to the interpretation of the law the agency administers when it is within the agency's expertise. Haley, 117 Wn.2d at 728. MQAC may rely on its experience and specialized knowledge to evaluate the evidence when finding unprofessional conduct. RCW 34.05.452(5); WAC 246-11-160(2); In re Disciplinary Proceeding Against Brown, 94 Wn. App. 7, 13-14, 972 P.2d 101 (1998).

The standard of proof in a medical disciplinary proceeding is that findings of fact must be proved by clear and convincing evidence. Nguyen v. Dep't of Health, Med. Quality Assur. Comm'n, 144 Wn.2d 516, 529, 29 P.3d 689 (2001). We review MQAC's findings of fact like any other proceeding under WAPA for substantial evidence. Ancier v. Dep't of Health, Med. Quality Assur. Comm'n, 140 Wn. App. 564, 572, 166 P.3d 829 (2007). Evidence is substantial if it is sufficient to persuade a reasonable person of the truth or correctness of the order. Ancier, 140 Wn. App. at 572-73. We take MQAC's evidence as true and draw all inferences in MQAC's favor. Ancier, 140 Wn. App. at 573. We will not weigh conflicting evidence or substitute our judgment regarding witness credibility for that of MQAC. Davis v. Dep't of Labor & Indus., 94 Wn.2d 119,

124, 615 P.2d 1279 (1980). Unchallenged agency factual findings are verities on appeal. Darkenwald v. Emp't Sec. Dep't, 183 Wn.2d 237, 244, 350 P.3d 647 (2015). After determining whether substantial evidence supports the findings of fact, the court determines whether the findings in turn support the conclusions of law and judgment. Nguyen, 144 Wn.2d at 530.

Unprofessional Conduct in Violation of RCW 18.130.180(1) and (4)

Dr. Dang claims that absent a finding that he owed a duty of care to Patients B or C, MQAC erred in deciding he violated RCW 18.130.180(1) and (4).

The plain language of RCW 18.130.180(1) and (4) does not require MQAC to find a duty of care. RCW 18.130.180(1) states, in pertinent part, that "unprofessional conduct" is "[t]he commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not." RCW 18.130.180(4) states, in pertinent part, that "unprofessional conduct" is "[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed."

MQAC concluded Dr. Dang violated RCW 18.130.180(1) and (4) by refusing to consult or treat Patients B and C. MQAC found the "refusal to consult" with the ER doctor concerning treatment and care of Patient B "lowered the standing of the profession in the eyes of the public" and "created an unreasonable risk of harm to Patient B." MQAC concluded that the "refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public."

Dr. Dang cites Khung Thi Lam v. Global Medical Systems, Inc., 127 Wn. App. 657, 111 P.3d 1258 (2005), to argue that without finding he owed a duty of care, MQAC could not conclude he violated RCW 18.130.180(1) and (4). Khung Thi Lam is inapposite. In Khung Thi Lam, the court held the plaintiff must establish a duty of care to prevail on a medical malpractice claim. Khung Thi Lam, 127 Wn. App. at 669.

Dr. Dang argues his conduct did not constitute an act of moral turpitude under RCW 18.130.180(1). In Haley, the Washington Supreme Court held that the conduct of a physician constitutes an act of moral turpitude if the physician abuses the status of the profession or lowers the standard of the profession in the eyes of the public. Haley, 117 Wn.2d at 731-32. The conduct "must indicate unfitness to bear the responsibilities of, and to enjoy the privileges of, the profession." Haley, 117 Wn.2d at 731.

> To perform their professional duties effectively, physicians must enjoy the trust and confidence of their patients. Conduct that lowers the public's esteem for physicians erodes that trust and confidence, and so undermines a necessary condition for the profession's execution of its vital role in preserving public health through medical treatment and advice.

Haley, 117 Wn.2d at 734.

Dr. Dang cites In re the License To Practice Pharmacy of Farina, 94 Wn. App. 441, 972 P.2d 531 (1999), to argue his conduct did not constitute moral turpitude. Farina is inapposite. In Farina, the court addressed the difference between moral turpitude and violation of a criminal statute. Farina, 94 Wn. App. at 460. The court concluded violation of a criminal statute does not necessarily constitute an act of moral turpitude. Farina, 94 Wn. App. at 460-61. Conduct that meets the definition of "moral turpitude" is an act of "inherent immorality." Farina, 94 Wn. App. at 460-61.

Dr. Dang also claims MQAC applied a subjective standard in determining he committed unprofessional conduct in violation of RCW 18.130.180(1). The record does not support his argument. Substantial evidence supports the MQAC finding that Dr. Dang refused to consult or treat Patients B and C and the findings support the conclusion that Dr. Dang violated RCW 18.130.180(1) and (4).

Dr. Dang asserts that because there is no distinction between the circumstances of Patient A and Patient B, MQAC erred in reaching a different conclusion for Patient B. The record does not support his argument. MQAC found Dr. Dang did not refuse to consult with the ER physician with respect to Patient A and said, "Patient A could follow up with the clinic on Monday (two days later)."

MQAC found Dr. Dang committed unprofessional conduct in violation of RCW 18.130.180(1) and (4) with respect to Patient B. MQAC found that unlike Patient A, Dr. Dang refused to consult with the ER doctor about the care and treatment of Patient B.

> [Dr. Dang]'s refusal to consult with the emergency room doctor concerning the care of Patient B lowered the standing of the profession in the eyes of the public. In addition, [Dr. Dang]'s refusal to consult with a fellow physician, acting in good faith to help a patient, created an unreasonable risk of harm to Patient B.

Challenge to MQAC Finding Violation of EMTALA

Dr. Dang contends MQAC did not have the authority to address whether he violated EMTALA. In his prehearing statement in the MQAC proceeding, Dr. Dang argued MQAC did not have the authority to address whether he violated EMTALA. However, Dr. Dang did not raise the argument again.

The Department of Health contends Dr. Dang waived the right to raise this argument on appeal. We agree. In an appeal of a decision governed by WAPA, an

appellant can raise an issue for the first time on only if (1) the appellant did not know and had no duty to discover facts that gave rise to the issue, (2) the appellant did not have an opportunity to raise the issue, or (3) the issue arose from a change in controlling law or a change in agency action and the interests of justice require resolution. RCW 34.05.554(1)(a)-(d); King County v. Boundary Review Bd. for King County, 122 Wn.2d 648, 668, 860 P.2d 1024 (1993). An appellant must do more than raise the issue below. Boundary Review Bd., 122 Wn.2d at 670; Kitsap All. of Prop. Owners v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd., 160 Wn. App. 250, 271-72, 255 P.3d 696 (2011).

Nonetheless, we note that under the plain and unambiguous language of RCW 18.130.180(7), MQAC has the authority to determine whether "[v]iolation of any state or federal statue or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice," constitutes unprofessional conduct.[6]

Dr. Dang contends the United States Department of Health and Human Services Secretary has the exclusive authority to initiate proceedings under EMTALA, and only the United States Court of Appeals has jurisdiction over EMTALA claims.

The Department of Health filed charges under the UDA, not EMTALA. The authority of MQAC under the UDA does not conflict with EMTALA. EMTALA specifically states that "[t]he provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). In Goldfarb v. Virginia State Bar,

[6] Emphasis added.

421 U.S. 773, 792, 95 S. Ct. 2004, 44 L. Ed. 2d 572 (1975), the United States Supreme Court recognized the compelling state interest in regulating healthcare professionals:

> [S]tates have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions.

Violation of RCW 18.130.180(7)

Dr. Dang argues the evidence does not support the conclusion that he violated RCW 18.130.180(7). We disagree. Substantial evidence supports the conclusion that Dr. Dang violated RCW 18.130.180(7) by refusing to treat Patient C in violation of federal law. The ER doctor transferred Patient C to St. Joseph for treatment because he "was experiencing an emergency medical condition, which had not been stabilized." MQAC found the "transfer to [St. Joseph] was appropriate. As such, the Respondent violated EMTALA when he failed to treat Patient C, while on call for [St. Joseph]." Unchallenged finding of fact 1.17 states that "[a]fter Patient C arrived at [St. Joseph], the Respondent was again contacted and he continued to refuse to consult or to treat Patient C."

Dr. Moore testified that she recommended transferring Patient C from the St. Clare emergency department to the St. Joseph emergency department for treatment. Dr. Moore testified the St. Joseph emergency department (ED) doctor called her after he transferred Patient C because Dr. Dang refused to treat Patient C. Dr. Moore testified:

> A So after the patient was transferred ED to ED, the ED physician at St. Joseph contacted Dr. Dang and he refused to come in and see the patient, so they called me.
> Q Okay. And what did you do?

A And I called Dr. Dang.
Q Okay. You spoke with him directly?
A Yes.
Q Okay. What did he tell you or did you ask him to accept the patient or do you recall the conversation?
A To the best of my recollection, I believe that I asked him to go in and see the patient as the on-call ear, nose and throat doctor.
Q Okay. And what did he respond?
A He said he would not go in to see the patient because the patient had come from St. Clare.
Q Okay. Did he give you any other reason why he would not or could not come in and see the patient?
A No.
Q Okay. Did he inform you that he had been injured —
A No.
Q — or that he was otherwise unavailable?
A No.

Substantial evidence supports the MQAC finding that Dr. Dang violated RCW 18.130.180(7) and EMTALA by refusing to treat Patient C after St. Clare transferred Patient C to St. Joseph.

Denial of Request To Admit Documentary Evidence

Dr. Dang contends MQAC abused its discretion by denying his request to admit documentary evidence. Dr. Dang argues the evidence would have refuted the testimony of Dr. Moore and denial of his request is prejudicial.

At the end of his case, Dr. Dang sought to introduce new documentary evidence to rebut the testimony of Dr. Moore. "The new evidence was in the form of a string of emails addressed to and from the Respondent, Dr. Moore, and a number of addressees who did not testify at [the] hearing." The MQAC findings describe the documentary evidence:

> The emails ranged in time from the year 2011 to 2014. [Dr. Dang's attorney] represented that: a) the emails were taken from the Respondent's personal home computer; b) the emails had been in the

> Respondent's possession; and c) they were not previously disclosed to [the Department of Health's attorney].
>
> WAC 246-11-390(7) states:
>
> Documentary evidence not offered in the prehearing conference will not be received into evidence at the adjudicative proceeding in the absence of a clear showing that the offering party had good cause for failing to produce the evidence at the prehearing conference.[7]

MQAC ruled Dr. Dang did not show good cause for failing previously to produce the documentary evidence:

> Here, Dr. Moore was identified at the prehearing conference as a witness. The Respondent knew or should have known that any documents containing prior statements by Dr. Moore could become relevant. This is especially true given that the documents have been in the Respondent's sole possession since 2011 and 2014, respectively. Thus, these documents should have been disclosed if the Respondent desired to have them become part of the record. Moreover, any uncertainties pertaining to Dr. Moore's testimony could have been resolved by deposing her. However, the Respondent's failure to do either has resulted in prejudice to the Department at this stage of the proceeding. Consequently, the Respondent has failed to demonstrate the necessary good cause for failing to produce the evidence at the prehearing conference.[8]

The record supports the MQAC finding that Dr. Dang did not show good cause because he did not produce the documentary evidence at the prehearing conference.

RCW 34.05.461(8)(a)

Dr. Dang argues the final order should be reversed because MQAC did not issue the final order within the 90-day time limit under RCW 34.05.461(8)(a). The Department of Health argues the 90-day time limit is directory, not mandatory. We agree with the Department of Health.

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[7] Dr. Dang asserts MQAC erred by not engaging in an analysis under Burnet v. Spokane Ambulance, 131 Wn.2d 484, 933 P.2d 1036 (1997). Burnet does not apply to an administrative proceeding. WAC 246-11-390 controls.

[8] Footnote omitted.

RCW 34.05.461(8)(a) states, in pertinent part, that "final orders shall be served in writing within ninety days after conclusion of the hearing or after submission of memos, briefs, or proposed findings . . . unless this period is waived or extended for good cause shown." A statute setting a time within which a public officer is to perform an official act is directory unless the nature of the act or the language of the statute makes clear that the time designation limits the power of the officer. Niichel v. Lancaster, 97 Wn.2d 620, 623-24, 647 P.2d 1021 (1982). When the time for or manner of performing the authorized action is not essential to the purpose of the statute, the time and manner provisions are considered directory. Niichel, 97 Wn.2d at 624.

Amended Findings of Fact, Conclusions of Law, and Final Order

Dr. Dang cites RCW 34.05.470(3) to argue the Amended Findings of Fact, Conclusions of Law, and Final Order is unlawful because the presiding officer did not comply with the 20-day time limit to file an amended final order.

The Department of Health filed a timely motion for reconsideration of the final order to correct two scrivener's errors. Dr. Dang did not file a response to the motion or object. On December 20, 2017, MQAC issued an amended final order correcting the two scrivener's errors:

> [MQAC] notes that two Scrivener's errors occurred in the Final Order. A Scrivener's error appears in Paragraph 1.3, which reads "[t]he Respondent was employed by [St. Joseph] at all times . . . ["] instead of "[t]he Respondent was employed by Group Health Cooperative at all times relevant to this matter." In addition, a Scrivener's error appears in Paragraph 1.10, which reads "[s]pecifically, the Respondent was not on-call at [St. Joseph] . . . ," instead of "[s]pecifically, the Respondent was not on-call at St. Clare Hospital and thus had no duty to treat or accept the transfer of Patient A."[9]

[9] Emphasis in original; some alteration in original.

Dr. Dang argues that because he filed the petition for judicial review in superior court before the presiding officer issued the amended final order, CR 60(a) controls. But the civil rules do not apply to administrative agency proceedings. See DeLacey v. Clover Park Sch. Dist., 117 Wn. App. 291, 296, 69 P.3d 877 (2003).

Due Process

For the first time on appeal, Dr. Dang contends MQAC violated his procedural right to due process on a number of grounds. Subject to certain limited exceptions that are not applicable here, RCW 34.05.554(1) bars a litigant from raising issues on appeal not raised before the agency. With the exception of his claim that MQAC did not consider the telephonic testimony, we decline to consider the arguments he raises for the first time on appeal.

Procedural due process requires notice and an opportunity to be heard " 'at a meaningful time and in a meaningful manner.' " Amunrud v. Bd. of Appeals, 158 Wn.2d 208, 216, 143 P.3d 571 (2006)[10] (quoting Mathews v. Eldridge, 424 U.S. 319, 333, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976)). "The process due depends on what is fair in a particular context." In re Det. of Morgan, 180 Wn.2d 312, 320, 330 P.3d 774 (2014). In Mathews, the United States Supreme Court articulated a balancing test to aid in determining when, and to what extent, procedural protections are required:

> [D]ue process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Mathews, 424 U.S. at 335.

[10] Internal quotation marks omitted.

Dr. Dang contends he did not have a meaningful opportunity to be heard during the three-day administrative hearing. The record does not support his argument. Dr. Dang was represented by counsel, he called expert witnesses to testify on his own behalf, his practice partner testified, he testified, and MQAC admitted documentary evidence he presented.

The transcript of the MQAC hearing indicates the testimony of the witnesses who testified by telephone is not "audible." Dr. Dang contends that because the transcript shows the testimony of his expert witnesses Dr. Bitterman and Dr. Pokorny and the testimony of Dr. Sliva was "not audible," MQAC ignored that testimony. The record does not support his argument.

The witnesses testified at the hearing. The Amended Findings of Fact, Conclusions of Law, and Final Order makes clear that MQAC, Dr. Dang, his attorney, and the attorney for the Department of Health heard the testimony of Dr. Sliva, Dr. Bitterman, and Dr. Pokorny. The Department of Health attorney addressed the testimony of these witnesses in closing argument. Dr. Dang's attorney cited and relied on the testimony of Dr. Sliva, Dr. Bitterman, and Dr. Pokorny in closing argument. The record shows that in the decision, MQAC did not rely on the transcript from the hearing. The transcript of the hearing is not prepared until after a petition for judicial review is filed. See RCW 34.05.566.[11]

[11] RCW 34.05.566 states, in pertinent part, "(1) Within thirty days after service of the petition for judicial review, or within further time allowed by the court or by other provision of law, the agency shall transmit to the court the original or a certified copy of the agency record for judicial review of the agency action."

We affirm the Amended Findings of Fact, Conclusions of Law, and Final Order.[12]

Schindler, J.

WE CONCUR:

Leach, J.

Appelwick, C.J.

[12] The Department of Health does not contest the determination that the effective date of the two-year oversight monitoring period is May 26, 2017.

Appendix B

(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

(C) use electronic medical records, health information technology, and individualized plans of care.

(5) Limitation on number of practices

In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

(6) Waiver

The Secretary may waive such provisions of this subchapter and subchapter XI as the Secretary determines necessary in order to implement the demonstration program.

(7) Administration

Chapter 35 of title 44 shall not apply to this section.

(f) Evaluation and monitoring

(1) In general

The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) Monitoring applicable beneficiaries

The Secretary may monitor data on expenditures and quality of services under this subchapter after an applicable beneficiary discontinues receiving services under this subchapter through a qualifying independence at home medical practice.

(g) Reports to Congress

The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this subchapter, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(h) Funding

For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this subchapter and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Termination

(1) Mandatory termination

The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) Permissive termination

The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866E, formerly § 1866D, as added and renumbered § 1866E, Pub. L. 111–148, title III, § 3024, title X, § 10308(b)(2), Mar. 23, 2010, 124 Stat. 404, 942.)

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsecs. (c) and (d)(1)(A), (B), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs

the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

[1] So in original. Probably should be followed by a comma.

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term ''emergency medical condition'' means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term ''participating hospital'' means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term ''to stabilize'' means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term ''stabilized'' means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emer-

gency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term ''transfer'' means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term ''hospital'' includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1867, as added Pub. L. 99–272, title IX, §9121(b), Apr. 7, 1986, 100 Stat. 164; amended Pub. L. 99–509, title IX, §9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 99–514, title XVIII, §1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, §4009(a)(1), formerly §4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330–56, 1330–57; Pub. L. 100–360, title IV, §411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub. L. 100–485, title VI, §608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xiv), 6211(a)–(h), Dec. 19, 1989, 103 Stat. 2154, 2245–2248; Pub. L. 101–508, title IV, §§4008(b)(1)–(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388–44, 1388–117, 1388–124, renumbered and amended Pub. L. 103–432, title I, §160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, §736(a)(14), title IX, §944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423.)

REFERENCES IN TEXT

Part B of subchapter XI of this chapter, referred to in subsec. (d)(3), is classified to section 1320c et seq. of this title.

PRIOR PROVISIONS

A prior section 1395dd, act Aug. 14, 1935, ch. 531, title XVIII, §1867, as added July 30, 1965, Pub. L. 89–97, title I, §102(a), 79 Stat. 329; amended Jan. 2, 1968, Pub. L. 90–248, title I, §164(a), 81 Stat. 873; Oct. 30, 1972, Pub. L. 92–603, title II, §288, 86 Stat. 1457, related to creation, composition, meetings, and functions of the Health Insurance Benefits Advisory Council and the appointment of a Chairman and members thereto, and qualifications, terms of office, compensation, and reimbursement of travel expenses of members, prior to repeal by Pub. L. 98–369, div. B, title III, §2349(a), July 18, 1984, 98 Stat. 1097, eff. July 18, 1984.

AMENDMENTS

2003—Subsec. (d)(1)(B). Pub. L. 108–173, §736(a)(14)(A), substituted ''if the violation is'' for ''if the violation is is'' in concluding provisions.

Subsec. (d)(3). Pub. L. 108–173, §944(c)(1), inserted ''or in terminating a hospital's participation under this subchapter'' after ''in imposing sanctions under paragraph (1)'' and inserted at end ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''

Subsec. (d)(4). Pub. L. 108–173, §944(b), added par. (4).

Subsec. (e)(1)(B). Pub. L. 108–173, §736(a)(14)(B), substituted ''a pregnant woman'' for ''a pregnant women''.

Subsec. (e)(2). Pub. L. 108–173, §736(a)(14)(C), substituted ''means a hospital'' for ''means hospital''.

1997—Subsec. (e)(5). Pub. L. 105–33 substituted ''critical access'' for ''rural primary care''.

1994—Subsec. (d)(3). Pub. L. 103–432, §160(d)(5)(A), made technical amendment to Pub. L. 101–508, §4207(a)(1)(A). See 1990 Amendment note below.

1990—Subsec. (c)(2)(C). Pub. L. 101–508, §4008(b)(3)(A)(iii), substituted ''subsection (d)(1)(C)'' for ''subsection (d)(2)(C)''.

Subsec. (d)(1). Pub. L. 101–508, §4008(b)(3)(A)(i), (ii), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: ''If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

''(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

''(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.''

Subsec. (d)(1)(B). Pub. L. 101–508, §4207(a)(2), (3), formerly §4027(a)(2), (3), as renumbered by Pub. L. 103–432, §160(d)(4), which directed amendment of par. (2)(B) by substituting ''negligently'' for ''knowingly'' and ''is gross and flagrant or is repeated'' for ''knowing and willful or negligent'', was executed by making the substitutions in par. (1)(B) to reflect the probable intent of Congress and the intervening redesignation of par. (2) as (1) by Pub. L. 101–508, §4008(b)(3)(A)(ii). See above.

Subsec. (d)(2). Pub. L. 101–508, §4008(b)(3)(A)(ii), redesignated par. (3) as (2). Former par. (2) redesignated (1).

Subsec. (d)(2)(A). Pub. L. 101–508, §4008(b)(1), (2), substituted ''negligently'' for ''knowingly'' and inserted

''(or not more than $25,000 in the case of a hospital with less than 100 beds)'' after ''$50,000''.

Subsec. (d)(3). Pub. L. 101–508, § 4207(a)(1)(A), formerly § 4027(a)(1)(A), as renumbered and amended by Pub. L. 103–432, § 160(d)(4), (5)(A), added par. (3). Former par. (3) redesignated (2).

Subsec. (i). Pub. L. 101–508, § 4207(k)(3), formerly § 4027(k)(3), as renumbered by Pub. L. 103–432, § 160(d)(4), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: ''A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.''

1989—Pub. L. 101–239, § 6211(h)(2)(A), struck out ''active'' before ''labor'' in section catchline.

Subsec. (a). Pub. L. 101–239, § 6211(h)(2)(B), which directed the amendment of subsec. (a) by striking out ''or to determine if the individual is in active labor (within the meaning of section (e)(2) of this section)'' was executed by striking out ''or to determine if the individual is in active labor (within the meaning of subsection (e)(2) of this section)'' after ''exists''.

Pub. L. 101–239, § 6211(a), substituted ''hospital's emergency department, including ancillary services routinely available to the emergency department,'' for ''hospital's emergency department''.

Subsec. (b). Pub. L. 101–239, § 6211(h)(2)(C), struck out ''active'' before ''labor'' in heading.

Subsec. (b)(1). Pub. L. 101–239, § 6211(h)(2)(D)(i), struck out ''or is in active labor'' after ''emergency medical condition'' in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 101–239, § 6211(h)(2)(D)(ii), struck out ''or to provide for treatment of the labor'' after ''stabilize the medical condition''.

Subsec. (b)(2). Pub. L. 101–239, § 6211(b)(1), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,'' after ''in that paragraph'', substituted ''and treatment.'' for ''or treatment.'', and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.''

Subsec. (b)(3). Pub. L. 101–239, § 6211(b)(2), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer,'' after ''subsection (c) of this section'' and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.''

Subsec. (c). Pub. L. 101–239, § 6211(g)(1)(A), substituted ''individual'' for ''patient'' in heading.

Subsec. (c)(1). Pub. L. 101–239, § 6211(c)(4), (g)(1)(B), (h)(2)(E), in introductory provisions, substituted ''an individual'' for ''a patient'', ''subsection (e)(3)(B) of this section)'' for ''subsection (e)(4)(B) of this section) or is in active labor'', and ''the individual'' for ''the patient'', and inserted at end ''A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.''

Subsec. (c)(1)(A)(i). Pub. L. 101–239, § 6211(c)(1), (g)(1)(B), substituted ''the individual'' for ''the patient'', ''the individual's behalf'' for ''the patient's behalf'', and ''after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility'' for ''requests that the transfer be effected''.

Subsec. (c)(1)(A)(ii). Pub. L. 101–239, § 6211(c)(2)(B), (3), (g)(1)(B), substituted ''has signed a certification that based upon the information available at the time of transfer'' for '', or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time'' and ''individual and, in the case of labor, to the unborn child'' for ''individual's medical condition''.

Subsec. (c)(1)(A)(iii). Pub. L. 101–239, § 6211(c)(2)(A), (C), (D), added cl. (iii).

Subsec. (c)(2)(A). Pub. L. 101–239, § 6211(c)(5), added subpar. (A). Former subpar. (A) redesignated (B).

Subsec. (c)(2)(B). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (A) as (B) and substituted ''the individual'' for ''the patient'' in cls. (i) and (ii). Former subpar. (B) redesignated (C).

Subsec. (c)(2)(C). Pub. L. 101–239, § 6211(c)(5)(A), (d), redesignated subpar. (B) as (C) and substituted ''sends to'' for ''provides'' and ''all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment'' for ''with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital''. Former subpar. (C) redesignated (D).

Subsec. (c)(2)(D). Pub. L. 101–239, § 6211(c)(5)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (D) as (E) and substituted ''individuals'' for ''patients''.

Subsec. (d)(2)(B). Pub. L. 101–239, § 6211(e)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.''

Subsec. (d)(2)(C). Pub. L. 101–239, § 6211(e)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: ''As used in this paragraph, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

''(i) is employed by, or under contract with, the participating hospital, and

''(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.''

Subsec. (e)(1). Pub. L. 101–239, § 6211(h)(1)(A), substituted ''means—'' and subpars. (A) and (B) for ''means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

''(A) placing the patient's health in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.''

Subsec. (e)(2). Pub. L. 101–239, § 6211(h)(1)(B), (E), redesignated par. (3) as (2) and struck out former par. (2) which defined ''active labor''.

Subsec. (e)(3). Pub. L. 101–239, § 6211(h)(1)(E), redesignated par. (4) as (3). Former par. (3) redesignated (2).

Subsec. (e)(4). Pub. L. 101–239, § 6211(h)(1)(E), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(4)(A). Pub. L. 101–239, § 6211(h)(1)(C), substituted ''emergency medical condition described in paragraph (1)(A)'' for ''emergency medical condition'', ''likely to result from or occur during'' for ''likely to result from'', and ''from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)'' for ''from a facility''.

Subsec. (e)(4)(B). Pub. L. 101–239, § 6211(h)(1)(D), inserted ''described in paragraph (1)(A)'' after ''emergency medical condition'', ''or occur during'' after ''to result from'', and '', or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)'' after ''from a facility''.

Subsec. (e)(5). Pub. L. 101–239, § 6211(h)(1)(E), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Pub. L. 101–239, § 6211(g)(2), substituted ''an individual'' for ''a patient'' in two places.

Subsec. (e)(6). Pub. L. 101–239, § 6211(h)(1)(E), redesignated par. (6) as (5).

Pub. L. 101–239, § 6003(g)(3)(D)(xiv), added par. (6).

Subsecs. (g) to (i). Pub. L. 101–239, § 6211(f), added subsecs. (g) to (i).

1988—Subsec. (d)(1). Pub. L. 100–360, § 411(b)(8)(A)(i), amended Pub. L. 100–203, § 4009(a)(2), see 1987 Amendment note below.

Subsec. (d)(2). Pub. L. 100–360, § 411(b)(8)(A)(i), as amended by Pub. L. 100–485, § 608(d)(18)(E), amended Pub. L. 100–203, § 4009(a)(1), see 1987 Amendment note below.

1987—Subsec. (d)(1). Pub. L. 100–203, § 4009(a)(2), which directed insertion of a provision related to imposing the sanction described in section 1395u(j)(2)(A) of this title, was amended generally by Pub. L. 100–360, § 411(b)(8)(A)(i), so that it does not amend par. (1).

Subsec. (d)(2). Pub. L. 100–203, § 4009(a)(1), as amended by Pub. L. 100–360, § 411(b)(8)(A)(i), as amended by Pub. L. 100–485, § 608(d)(18)(E), substituted subpars. (A) and (B) for ''In addition to the other grounds for imposition of a civil money penalty under section 1320a–7a(a) of this title, a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation.'', designated second sentence as subpar. (C), substituted ''this paragraph'' for ''the previous sentence'', and redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (C).

1986—Subsec. (b)(2), (3). Pub. L. 99–509 struck out ''legally responsible'' after ''individual (or a''.

Subsec. (e)(3). Pub. L. 99–514 struck out ''and has, under the agreement, obligated itself to comply with the requirements of this section'' after ''section 1395cc of this title''.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, § 944(c)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to terminations of participation initiated on or after the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(b)(1)–(3)(A) of Pub. L. 101–508 applicable to actions occurring on or after the first day of the sixth month beginning after Nov. 5, 1990, see section 4008(b)(4) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

Amendment by section 4207(a)(1)(A) of Pub. L. 101–508 effective on the first day of the first month beginning more than 60 days after Nov. 5, 1990, see section 4207(a)(1)(C) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

Section 4207(a)(4), formerly 4027(a)(4), of Pub. L. 101–508, as renumbered and amended by Pub. L. 103–432, title I, § 160(d)(4), (5)(B), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by paragraphs (2) and (3) [amending this section] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Section 6211(i) of Pub. L. 101–239 provided that: ''The amendments made by this section [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date.''

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Section 4009(a)(2), formerly § 4009(a)(3), of Pub. L. 100–203, as redesignated by Pub. L. 100–360, title IV, § 411(b)(8)(A)(ii), July 1, 1988, 102 Stat. 772, provided that: ''The amendments made by this subsection [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

EFFECTIVE DATE

Section 9121(c) of Pub. L. 99–272 provided that: ''The amendments made by this section [enacting this section and amending section 1395cc of this title] shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act [Apr. 7, 1986].''

SHORT TITLE

This section is popularly known as the Emergency Medical Treatment and Labor Act (EMTALA).

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP

Pub. L. 108–173, title IX, § 945, Dec. 8, 2003, 117 Stat. 2423, provided that:

''(a) ESTABLISHMENT.—The Secretary [of Health and Human Services] shall establish a Technical Advisory Group (in this section referred to as the 'Advisory Group') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term 'EMTALA' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

''(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

''(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

''(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or

cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

''(3) 2 shall represent patients;

''(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

''(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

''(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

''(1) shall review EMTALA regulations;

''(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

''(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

''(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

''(d) ADMINISTRATIVE MATTERS.—

''(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

''(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

''(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

''(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).''

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Pub. L. 108–173, title X, §1011, Dec. 8, 2003, 117 Stat. 2432, provided that:

''(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary [of Health and Human Services] $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

''(b) STATE ALLOTMENTS.—

''(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

''(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

''(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

''(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

''(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

''(c) USE OF FUNDS.—

''(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

''(2) DETERMINATION OF PAYMENT AMOUNTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

''(i) the amount that the provider demonstrates was incurred for the provision of such services; or

''(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

''(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

''(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

''(A) may establish different methodologies for types of eligible providers;

''(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

''(C) shall provide for the election by a hospital to receive either payments to the hospital for—

''(i) hospital and physician services; or

''(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

''(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

''(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made

under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

''(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

''(A) Undocumented aliens.

''(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

''(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a 'laser visa') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

''(d) APPLICATIONS; ADVANCE PAYMENTS.—

''(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

''(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

''(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

''(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE PROVIDER.—The term 'eligible provider' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

''(2) ELIGIBLE SERVICES.—The term 'eligible services' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

''(3) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

''(4) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

''(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(6) STATE.—The term 'State' means the 50 States and the District of Columbia.''

INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS

Section 4008(c) of Pub. L. 101–508 directed Secretary of Health and Human Services (acting through Inspector General of Department of Health and Human Services) to conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act (this section) relating to the examination and treatment of individuals with an emergency medical condition and women in labor, with Secretary to submit a report to Congress on the study not later than 1 year after Nov. 5, 1990.

§ 1395ee. Practicing Physicians Advisory Council; Council for Technology and Innovation

(a) Repealed. Pub. L. 111–148, title III, § 3134(b)(2), Mar. 23, 2010, 124 Stat. 435

(b) Council for Technology and Innovation

(1) Establishment

The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'').

(2) Composition

The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) Duties

The Council shall coordinate the activities of coverage, coding, and payment processes under this subchapter with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) Executive Coordinator for Technology and Innovation

The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, § 1868, as added Pub. L. 101–508, title IV, § 4112, Nov. 5, 1990, 104 Stat. 1388–64; amended Pub. L. 108–173, title IX, § 942(a), Dec. 8, 2003, 117 Stat. 2420; Pub. L. 111–148, title III, § 3134(b)(2), Mar. 23, 2010, 124 Stat. 435.)

PRIOR PROVISIONS

A prior section 1395ee, act Aug. 14, 1935, ch. 531, title XVIII, § 1868, as added July 30, 1965, Pub. L. 89–97, title I, § 102(a), 79 Stat. 329, provided for creation of a National Medical Review Committee, functions of such Committee, including submission of annual reports to the Secretary and Congress, employment of technical assistance, and for availability of assistance and data, prior to repeal by Pub. L. 90–248, title I, § 164(c), Jan. 2, 1968, 81 Stat. 874.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148 struck out subsec. (a) which related to the Practicing Physicians Advisory Council.

2003—Pub. L. 108–173, § 942(a)(1), inserted ''; Council for Technology and Innovation'' in section catchline.

1993, in the case of items or services furnished by a provider who, on or before Nov. 5, 1990, has furnished items or services for which payment may be made under part B of subchapter XVIII of this chapter, or Jan. 1, 1992, in the case of items or services furnished by any other provider, see section 4164(b)(4) of Pub. L. 101–508, set out as an Effective Date note under section 1320a–3a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Section 6411(d)(4)[(A)] of Pub. L. 101–239 provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and sections 1395y and 1396b of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].''

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360 set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Section 15 of Pub. L. 100–93 provided that:

''(a) IN GENERAL.—Except as provided in subsections (b), (c), (d), and (e), the amendments made by this Act [enacting sections 1395aaa and 1396r–2 of this title, amending this section, sections 704, 1320a–3, 1320a–5, 1320a–7a, 1320a–7b, 1320c–5, 1395u, 1395y, 1395cc, 1395ff, 1395nn, 1395rr, 1395ss, 1395ww, 1396a, 1396b, 1396h, 1396n, 1396s, and 1397d of this title, and section 824 of Title 21, Food and Drugs, transferring section 1396h of this title to section 1320a–7b of this title, repealing section 1395nn of this title, enacting provisions set out as a note under section 1320a–7b of this title, and amending provisions set out as a note under section 1396a of this title] shall become effective at the end of the fourteen-day period beginning on the date of the enactment of this Act [Aug. 18, 1987] and shall not apply to administrative proceedings commenced before the end of such period.

''(b) MANDATORY MINIMUM EXCLUSIONS APPLY PROSPECTIVELY.—Section 1128(c)(3)(B) of the Social Security Act [subsec. (c)(3)(B) of this section] (as amended by this Act), which requires an exclusion of not less than five years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act [Aug. 18, 1987].

''(c) EFFECTIVE DATE FOR CHANGES IN MEDICAID LAW.—(1) The amendments made by sections 5 and 8(f) [enacting section 1396r–2 of this title and amending sections 1396a and 1396s of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [subchapter XIX of this chapter] for calendar quarters beginning more than thirty days after the date of the enactment of this Act [Aug. 18, 1987], without regard to whether or not final regulations to carry out such amendment have been published by such date.

''(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

''(3) Subsection (j) of section 1128A of the Social Security Act [section 1320a–7a(j) of this title] (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

''(d) PHYSICIAN MISREPRESENTATIONS.—Clauses (ii) and (iii) of section 1128A(a)(1)(C) of the Social Security Act [section 1320a–7a(a)(1)(C)(ii), (iii) of this title], as amended by section 3(a)(1) of this Act, apply to claims presented for services performed on or after the effective date specified in subsection (a), without regard to the date the misrepresentation of fact was made.

''(e) CLARIFICATION OF MEDICAID MORATORIUM.—The amendments made by section 9 of this Act [amending provisions set out as a note under section 1396a of this title] shall apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984 [set out as a note under section 1396a of this title].

''(f) TREATMENT OF CERTAIN DENIALS OF PAYMENT.—For purposes of section 1128(b)(8)(B)(iii) of the Social Security Act [subsec. (b)(8)(B)(iii) of this section] (as amended by section 2 of this Act), a person shall be considered to have been excluded from participation under a program under title XVIII [subchapter XVIII of this chapter] if payment to the person has been denied under section 1862(d) of the Social Security Act [section 1395y(d) of this title], as in effect before the effective date specified in subsection (a).''

EFFECTIVE DATE OF 1986 AMENDMENT

Section 9317(d)(3) of Pub. L. 99–509 provided that: ''The provisions—

''(A) of paragraphs (1), (2), and (3) of section 1128(f) of the Social Security Act [subsec. (f)(1)–(3) of this section] (as added by the amendment made by subsection (c)) shall apply to judgments entered, findings made, and pleas entered, before, on, or after the date of the enactment of this Act [Oct. 21, 1986], and

''(B) of paragraph (4) of such section [subsec. (f)(4) of this section] shall apply to participation in a program entered into on or after the date of the enactment of this Act.''

EFFECTIVE DATE OF 1984 AMENDMENT

Section 2333(c) of Pub. L. 98–369 provided that: ''The amendments made by this section [amending this section] become effective on the date of the enactment of this Act [July 18, 1984] and shall apply to convictions of persons occurring after such date.''

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(k) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

§ 1320a–7a. Civil monetary penalties

(a) Improperly filed claims

Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1) of this section), a claim (as defined in subsection (i)(2) of this section) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or

should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the Federal health care program (as defined in section 1320a–7b(f) of this title) under which the claim was made pursuant to Federal law.[1]

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1395u(b)(3)(B)(ii) of this title, or (B) an agreement with a State agency (or other requirement of a State plan under subchapter XIX of this chapter) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1395u(h)(1) of this title, or (D) an agreement pursuant to section 1395cc(a)(1)(G) of this title;

(3) knowingly gives or causes to be given to any person, with respect to coverage under subchapter XVIII of this chapter of inpatient hospital services subject to the provisions of section 1395ww of this title, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under subchapter XVIII of this chapter or a State health care program in accordance with this subsection or under section 1320a–7 of this title and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under subchapter XVIII of this chapter or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1320a–5(b) of this title) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under subchapter XVIII of this chapter, or under a State health care program (as defined in section 1320a–7(h) of this title) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under subchapter XVIII of this chapter, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1320a–7b(f) of this title), for the provision of items or services for which payment may be made under such a program;

(7) commits an act described in paragraph (1) or (2) of section 1320a–7b(b) of this title;

(8)[2] knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or[3]

(9)[4] fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

(8)[2] orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

(9)[4] knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of subchapter XVIII, prescription drug plan sponsors under part D of subchapter XVIII, medicaid managed care organizations under subchapter XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;[5]

(10) knows of an overpayment (as defined in paragraph (4) of section 1320a–7k(d) of this title) and does not report and return the overpayment in accordance with such section;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil

[1] So in original. Probably should be ''law, or''.

[2] So in original. Two pars. (8) have been enacted.

[3] So in original. The word ''or'' probably should not appear.

[4] So in original. Two pars. (9) have been enacted.

[5] So in original. Probably should be followed by ''or''.

money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; in cases under paragraph (7), $50,000 for each such act,[6] in cases under paragraph (8),[7] $50,000 for each false record or statement,[6] or[8] in cases under paragraph (9),[9] $15,000 for each day of the failure described in such paragraph);[10] or in cases under paragraph (9),[11] $50,000 for each false statement or misrepresentation of a material fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a–7b(f)(1) of this title) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b) Payments to induce reduction or limitation of services

(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of subchapter XVIII of this chapter or to medical assistance under a State plan approved under subchapter XIX of this chapter, and

(B) are under the direct care of the physician,

the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under subchapter XVIII of this chapter for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of subchapter XVIII of this chapter, that an individual meets the requirements of section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title in the case of home health services furnished to the individual.

(c) Initiation of proceeding; authorization by Attorney General, notice, etc., estoppel, failure to comply with order or procedure

(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) of this section only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) of this section until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) of this section which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

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[6] So in original. The comma probably should be a semicolon.

[7] So in original. Probably is a reference to the first paragraph (8).

[8] So in original. The word ''or'' probably should not appear.

[9] So in original. Probably is a reference to the first paragraph (9).

[10] So in original. Probably should be ''paragraph;''.

[11] So in original. Probably is a reference to the second paragraph (9).

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) Amount or scope of penalty, assessment, or exclusion

In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b) of this section, the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Review by courts of appeals

Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court[12] the record in the proceeding as provided in section 2112 of title 28. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28.

(f) Compromise of penalties and assessments; recovery; use of funds recovered

Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under subchapter XIX of this chapter, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under subchapter V of this chapter, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1395i and 1395t of this title shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1320a–7b(f) of this title), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1395i(k)(2)(C) of this title.

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

[12] So in original. Probably should not be capitalized.

(g) Finality of determination respecting penalty, assessment, or exclusion

A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) of this section shall be final upon the expiration of the sixty-day period referred to in subsection (e) of this section. Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) of this section may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h) Notification of appropriate entities of finality of determination

Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) of this section becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1395aa(a) and 1396a(a)(33) of this title) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(i) Definitions

For the purposes of this section:

(1) The term ''State agency'' means the agency established or designated to administer or supervise the administration of the State plan under subchapter XIX of this chapter or designated to administer the State's program under subchapter V of this chapter or division A[13] of subchapter XX of this chapter.

(2) The term ''claim'' means an application for payments for items and services under a Federal health care program (as defined in section 1320a–7b(f) of this title).

(3) The term ''item or service'' includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term ''agency of the United States'' includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term ''beneficiary'' means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term ''remuneration'' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term ''remuneration'' does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n) of this section, any permissible practice described in any subparagraph of section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after August 21, 1996;

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1395*l*(t)(5)(B)[13] of this title; or[8]

(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1320a–7b(f) of this title and designated by the Secretary under regulations);

(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under subchapter XVIII or a State health care program (as defined in section 1320a–7(h) of this title);

(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services are not offered as part of any advertisement or solicitation;

(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under

[13] See References in Text note below.

subchapter XVIII or a State health care program (as so defined);

(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of subchapter XVIII or an MA organization offering an MA–PD plan under part C of such subchapter of any copayment for the first fill of a covered part D drug (as defined in section 1395w–102(e) of this title) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.

(7) The term ''should know'' means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(j) Subpoenas

(1) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II of this chapter. The Secretary may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1320a–7 of this title to the Inspector General of the Department of Health and Human Services.

(k) Injunctions

Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(*l*) Liability of principal for acts of agent

A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m) Claims within jurisdiction of other departments or agencies

(1) For purposes of this section, with respect to a Federal health care program not contained in this chapter, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n) Safe harbor for payment of medigap premiums

(1) Subparagraph (B) of subsection (i)(6) of this section shall not apply to a practice described in paragraph (2) unless—

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of subchapter XVIII of this chapter pursuant to section 426–1 of this title.

(Aug. 14, 1935, ch. 531, title XI, § 1128A, as added Pub. L. 97–35, title XXI, § 2105(a), Aug. 13, 1981, 95 Stat. 789; amended Pub. L. 97–248, title I, § 137(b)(26), Sept. 3, 1982, 96 Stat. 380; Pub. L. 98–369, div. B, title III, §§ 2306(f)(1), 2354(a)(3), July 18, 1984, 98 Stat. 1073, 1100; Pub. L. 99–509, title IX, §§ 9313(c)(1), 9317(a), (b), Oct. 21, 1986, 100 Stat. 2003, 2008; Pub. L. 100–93, § 3, Aug. 18, 1987, 101 Stat. 686; Pub. L. 100–203, title IV, §§ 4039(h)(1), 4118(e)(1), (6)–(10), Dec. 22, 1987, 101 Stat. 1330–155, as amended Pub. L. 100–360, title IV, § 411(e)(3), (k)(10)(B)(ii), (D), July 1, 1988, 102 Stat. 775, 794, 795; Pub. L. 100–360, title II, § 202(c)(2), July 1, 1988, 102 Stat. 715; Pub. L.

100–485, title VI, § 608(d)(26)(H)–(K)(i), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 101–234, title II, § 201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, § 6003(g)(3)(D)(i), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 101–508, title IV, §§ 4204(a)(3), 4207(h), formerly 4027(h), 4731(b)(1), 4753, Nov. 5, 1990, 104 Stat. 1388–109, 1388–123, 1388–195, 1388–208, renumbered § 4207(h), Pub. L. 103–432, title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–191, title II, §§ 231(a)–(e), (h), 232(a), Aug. 21, 1996, 110 Stat. 2012–2015; Pub. L. 105–33, title IV, §§ 4201(c)(1), 4304(a), (b), 4331(e), 4523(c), Aug. 5, 1997, 111 Stat. 373, 383, 396, 449; Pub. L. 105–277, div. J, title V, § 5201(a), (b)(1), Oct. 21, 1998, 112 Stat. 2681–916; Pub. L. 111–148, title VI, §§ 6402(d)(2), 6408(a), 6703(d)(3)(B), Mar. 23, 2010, 124 Stat. 757, 770, 804.)

REFERENCES IN TEXT

The Federal Rules of Civil Procedure, referred to in subsec. (c)(1), are set out in the Appendix to Title 28, Judiciary and Judicial Procedure.

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (f)(3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

Division A of subchapter XX, referred to in subsec. (i)(1), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

Section 1395*l*(t)(5)(B) of this title, referred to in subsec. (i)(6)(E), was redesignated section 1395*l*(t)(8)(B) of this title by Pub. L. 106–113, div. B, § 1000(a)(6) [title II, §§ 201(a)(1), 202(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336, 1501A–342.

The Inspector General Act of 1978, referred to in subsec. (m)(2)(B), is Pub. L. 95–452, Oct. 12, 1978, 92 Stat. 1101, which is set out in the Appendix to Title 5, Government Organization and Employees.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, § 6408(a)(3)(B), which directed substitution of ''act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)'' for ''act)'' in first sentence, was executed by making the substitution for ''act'' to reflect the probable intent of Congress. See amendment by Pub. L. 111–148, § 6402(d)(2)(A)(iv) below.

Pub. L. 111–148, § 6408(a)(3)(A), which directed substitution of ''in cases under paragraph (7)'' for ''or in cases under paragraph (7)'' in first sentence, was executed by making the substitution for ''in cases under paragraph (7)'' resulting in no change in text and to reflect the probable intent of Congress. See amendment by Pub. L. 111–148, § 6402(d)(2)(A)(iv) below.

Pub. L. 111–148, § 6402(d)(2)(A)(iv), (v), in concluding provisions, struck out ''or'' after ''prohibited relationship occurs;'' and substituted ''act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)'' for ''act)'' and ''purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact)'' for ''purpose)''.

Subsec. (a)(1)(D). Pub. L. 111–148, § 6402(d)(2)(A)(i), which directed substitution of ''was excluded from the Federal health care program (as defined in section 1320a–7b(f) of this title) under which the claim was made pursuant to Federal law.'' for '' 'was excluded' and all that follows through the period at the end'', was executed by making the substitution for ''was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1320a–7, 1320c–5, 1320c–9(b) (as in effect on September 2, 1982), 1395y(d) (as in effect on August 18, 1987), or 1395cc(b) of this title or as a result of the application of the provisions of section 1395u(j)(2) of this title, or'', to reflect the probable intent of Congress, because there was no period at the end.

Subsec. (a)(6). Pub. L. 111–148, §§ 6402(d)(2)(A)(ii), 6408(a)(1), amended par. (6) identically, striking out ''or'' at the end.

Subsec. (a)(8), (9). Pub. L. 111–148, § 6408(a)(2), added pars. (8) and (9) relating to false or fraudulent claims for payment for items and services furnished under a Federal health care program and failure to grant timely access to the Inspector General of the Department of Health and Human Services, respectively.

Pub. L. 111–148, § 6402(d)(2)(A)(iii), added pars. (8) and (9) relating to orders or prescriptions for persons excluded from a Federal health care program; and false statements, omissions, or misrepresentations in applications, bids, or contracts to participate or enroll as a provider of services or a supplier under a Federal health care program, respectively.

Subsec. (a)(10). Pub. L. 111–148, § 6402(d)(2)(A)(iii), added par. (10).

Subsec. (i)(1). Pub. L. 111–148, § 6703(d)(3)(B), inserted ''division A of'' after ''subchapter V of this chapter or''.

Subsec. (i)(6)(C). Pub. L. 111–148, § 6402(d)(2)(B)(i), struck out ''or'' at the end.

Subsec. (i)(6)(D). Pub. L. 111–148, § 6402(d)(2)(B)(ii), in subpar. (D) relating to incentives given to individuals to promote delivery, substituted a semicolon for the period.

Subsec. (i)(6)(E). Pub. L. 111–148, § 6402(d)(2)(B)(iii), redesignated subpar. (D) relating to a reduction in copayment amount for covered OPD services as (E) and substituted ''; or'' for the period.

Subsec. (i)(6)(F) to (I). Pub. L. 111–148, § 6402(d)(2)(B)(iv), added pars. (F) to (I).

1998—Subsec. (i)(6)(B). Pub. L. 105–277, § 5201(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''any permissible waiver as specified in section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;''.

Subsec. (n). Pub. L. 105–277, § 5201(b)(1), added subsec. (n).

1997—Subsec. (a). Pub. L. 105–33, § 4304(b)(2), in concluding provisions, substituted ''occurs; or in cases under paragraph (7), $50,000 for each such act).'' for ''occurs).'' and inserted ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)'' after ''of such claim''.

Subsec. (a)(6). Pub. L. 105–33, § 4304(a), added par. (6).

Subsec. (a)(7). Pub. L. 105–33, § 4304(b)(1), added par. (7).

Subsec. (b)(1). Pub. L. 105–33, § 4201(c)(1), substituted ''critical access'' for ''rural primary care'' in introductory and concluding provisions.

Subsec. (i)(6)(A)(iii). Pub. L. 105–33, § 4331(e)(1), inserted ''or'' at end of subcl. (I), struck out ''or'' at end of subcl. (II), and struck out subcl. (III) which read as follows: ''provides for any permissible waiver as specified in section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;''.

Subsec. (i)(6)(B). Pub. L. 105–33, § 4523(c)(1), which directed amendment of par. (6) by striking ''or'' at end of subpar. (B), could not be executed because the word ''or'' did not appear at end of subpar. (B) subsequent to amendment by Pub. L. 105–33, § 4331(e)(2), (3). See below.

Pub. L. 105–33, § 4331(e)(3), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (i)(6)(C). Pub. L. 105–33, § 4523(c)(2), which directed amendment of par. (6) by substituting ''; or'' for the period at end of subpar. (C), could not be executed because there was not a period at the end of subpar. (C)

subsequent to amendment by Pub. L. 105–33, § 4331(e)(2). See below.

Pub. L. 105–33, § 4331(e)(2), redesignated subpar. (B) as (C). Former subpar. (C) redesignated (D).

Subsec. (i)(6)(D). Pub. L. 105–33, § 4523(c), added subpar. (D) relating to a reduction in copayment amount for covered OPD services.

Pub. L. 105–33, § 4331(e)(2), redesignated subpar. (C), relating to incentives given to individuals to promote delivery, as (D).

1996—Subsec. (a). Pub. L. 104–191, § 231(c), in concluding provisions, substituted ''$10,000'' for ''$2,000'', inserted ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given'', and substituted ''3 times the amount'' for ''twice the amount''.

Pub. L. 104–191, § 231(a)(1), in concluding provisions, substituted ''Federal health care programs (as defined in section 1320a–7b(f)(1) of this title)'' for ''programs under subchapter XVIII of this chapter''.

Subsec. (a)(1). Pub. L. 104–191, § 231(d)(1)(A), inserted ''knowingly'' before ''presents'' in introductory provisions.

Subsec. (a)(1)(A). Pub. L. 104–191, § 231(e)(1), substituted ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'' for ''claimed,''.

Subsec. (a)(1)(E). Pub. L. 104–191, § 231(e)(2)–(4), added subpar. (E).

Subsec. (a)(2). Pub. L. 104–191, § 231(d)(1)(A), inserted ''knowingly'' before ''presents''.

Subsec. (a)(3). Pub. L. 104–191, § 231(d)(1)(B), substituted ''knowingly gives or causes to be given'' for ''gives''.

Subsec. (a)(4). Pub. L. 104–191, § 231(b), added par. (4).

Subsec. (a)(5). Pub. L. 104–191, § 231(h)(1), added par. (5).

Subsec. (b)(3). Pub. L. 104–191, § 232(a), added par. (3).

Subsec. (f)(3), (4). Pub. L. 104–191, § 231(a)(2), added par. (3) and redesignated former par. (3) as (4).

Subsec. (i)(2). Pub. L. 104–191, § 231(a)(3)(A), substituted ''a Federal health care program (as defined in section 1320a–7b(f) of this title)'' for ''subchapter V, XVIII, XIX, or XX of this chapter''.

Subsec. (i)(4). Pub. L. 104–191, § 231(a)(3)(B), substituted ''a Federal health care program (as so defined)'' for ''a health insurance or medical services program under subchapter XVIII or XIX of this chapter''.

Subsec. (i)(5). Pub. L. 104–191, § 231(a)(3)(C), substituted ''a Federal health care program (as so defined)'' for ''subchapter V, XVIII, XIX, or XX of this chapter''.

Subsec. (i)(6). Pub. L. 104–191, § 231(h)(2), added par. (6).

Subsec. (i)(7). Pub. L. 104–191, § 231(d)(2), added par. (7).

Subsec. (m). Pub. L. 104–191, § 231(a)(4), added subsec. (m).

1990—Subsec. (b)(1). Pub. L. 101–508, § 4731(b)(1), struck out ''or an entity with a contract under section 1396b(m) of this title'' before ''knowingly makes a payment'' in introductory provisions.

Pub. L. 101–508, § 4204(a)(3), struck out '', an eligible organization with a risk-sharing contract under section 1395mm of this title,'' after ''primary care hospital'' in introductory provisions, struck out ''or organization'' after ''primary care hospital'' in concluding provisions, redesignated subpar. (C) as (B), and struck out former subpar. (B) which read as follows: ''in the case of an eligible organization or an entity, are enrolled with the organization or entity, and''.

Subsec. (j). Pub. L. 101–508, § 4753, made an amendment to subsec. (j) identically to that of Pub. L. 101–508, § 4207(h). See below.

Pub. L. 101–508, § 4207(h), formerly § 4027(h), as renumbered by Pub. L. 103–432, designated existing provisions as par. (1) and added par. (2).

1989—Subsec. (a)(1)(D), (2)(C), (4). Pub. L. 101–234 repealed Pub. L. 100–360, § 202(c), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(1). Pub. L. 101–239 substituted ''hospital or a rural primary care hospital'' for ''hospital'' in introductory and concluding provisions.

1988—Subsec. (a). Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(10)(A), see 1987 Amendment note below.

Subsec. (a)(1). Pub. L. 100–360, § 411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, § 608(d)(26)(H), amended directory language of Pub. L. 100–203, § 4118(e)(1), see 1987 Amendment note below.

Subsec. (a)(1)(D). Pub. L. 100–360, § 411(k)(10)(D), as amended by Pub. L. 100–485, § 608(d)(26)(K)(i), added Pub. L. 100–203, § 4118(e)(6), see 1987 Amendment note below.

Pub. L. 100–360, § 202(c)(2)(A), struck out ''or'' after semicolon.

Subsec. (a)(2)(C). Pub. L. 100–360, § 202(c)(2)(B), inserted ''or to be a participating pharmacy under section 1395u(*o*) of this title'' after ''section 1395u(h)(1) of this title''.

Subsec. (a)(3). Pub. L. 100–360, § 411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, § 608(d)(26)(H), made technical amendment to directory language of Pub. L. 100–203, § 4118(e)(1)(A), see 1987 Amendment note below.

Subsec. (a)(4). Pub. L. 100–360, § 202(c)(2)(C)–(E), added par. (4) relating to participating or nonparticipating pharmacies.

Subsec. (b)(1)(A). Pub. L. 100–360, § 411(e)(3), added Pub. L. 100–203, § 4039(h)(1)(A), see 1987 Amendment note below.

Subsec. (b)(2). Pub. L. 100–360, § 411(e)(3), added Pub. L. 100–203, § 4039(h)(1)(B), see 1987 Amendment note below.

Subsec. (c)(1). Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(7), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(8), see 1987 Amendment note below.

Subsec. (i)(1). Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(9), see 1987 Amendment note below.

Subsec. (i)(2). Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(10)(B), see 1987 Amendment note below.

Subsec. (i)(5). Pub. L. 100–485, § 608(d)(26)(J), amended directory language of Pub. L. 100–203, § 4118(e)(10)(C), see 1987 Amendment note below.

Pub. L. 100–360, § 411(k)(10)(D), added Pub. L. 100–203, § 4118(e)(10)(C), see 1987 Amendment note below.

Subsec. (*l*). Pub. L. 100–485, § 608(d)(26)(I), inserted ''for penalties, assessments, and an exclusion'' after ''liable''.

Pub. L. 100–360, § 411(k)(10)(B)(ii)(III), added Pub. L. 100–203, § 4118(e)(1)(B), see 1987 Amendment note below.

1987—Subsec. (a). Pub. L. 100–203, § 4118(e)(10)(A), as added by Pub. L. 100–360, § 411(k)(10)(D), inserted '', but excluding a beneficiary, as defined in subsection (i)(5) of this section'' in introductory provisions.

Pub. L. 100–93, § 3(a)(3)(B), in concluding provisions, inserted ''(or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given)'' before period at end of first sentence, and inserted at end ''In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under subchapter XVIII of this chapter and to direct the appropriate State agency to exclude the person from participation in any State health care program.''

Subsec. (a)(1). Pub. L. 100–203, § 4118(e)(1)(A), formerly § 4118(e)(1), as amended by Pub. L. 100–360, § 411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, § 608(d)(26)(H), substituted ''or should know'' for ''or has reason to know'' in subpars. (A) to (C).

Pub. L. 100–93, § 3(a)(1), substituted ''the Secretary determines'' for ''the Secretary determines is for a medical or other item or service'' in introductory provisions

and substituted subpars. (A) to (D) for former subpars. (A) and (B) which read as follows:

''(A) that the person knows or has reason to know was not provided as claimed, or

''(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1320a–7, 1320c–9(b), or 1395y(d) of this title, or pursuant to a determination by the Secretary under section 1395cc(b)(2) of this title with respect to which the Secretary has initiated termination proceedings; or''.

Subsec. (a)(1)(D). Pub. L. 100–203, §4118(e)(6), as added by Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(i), substituted ''excluded from'' for ''excluded under'' and inserted ''or as a result of the application of the provisions of section 1395u(j)(2) of this title''.

Subsec. (a)(2). Pub. L. 100–93, §3(a)(2), inserted ''(or other requirement of a State plan under subchapter XIX of this chapter)'' after ''State agency'' in subpar. (B) and added subpar. (D).

Subsec. (a)(3). Pub. L. 100–203, §4118(e)(1)(A), as amended by Pub. L. 100–360, §411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, §608(d)(26)(H), substituted ''or should know'' for ''or has reason to know''.

Pub. L. 100–93, §3(a)(3)(A), added par. (3).

Subsec. (b)(1)(A). Pub. L. 100–203, §4039(h)(1)(A), as added by Pub. L. 100–360, §411(e)(3), substituted ''subchapter XVIII'' for ''subchapter XVII''.

Subsec. (b)(2). Pub. L. 100–203, §4039(h)(1)(B), as added by Pub. L. 100–360, §411(e)(3), substituted ''$2,000 for each'' for ''$2,000 for''.

Subsec. (c)(1). Pub. L. 100–203, §4118(e)(7), as added by Pub. L. 100–360, §411(k)(10)(D), inserted '', request for payment, or other occurrence described in this section'' and '', the request for payment was made, or the occurrence took place''.

Pub. L. 100–93, §3(b), (c), substituted ''penalty, assessment, or exclusion'' for ''penalty or assessment'' and inserted provision that the Secretary not initiate an action under this section with respect to a claim later than six years after the claim was presented and that the Secretary initiate an action in the manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

Subsec. (d). Pub. L. 100–93, §3(c), substituted ''penalty, assessment, or exclusion'' for ''penalty or assessment'' in introductory provisions.

Subsec. (f)(1)(A). Pub. L. 100–93, §3(d), substituted ''bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid'' for ''equal to the State's share of the amount paid by the State agency''.

Subsec. (g). Pub. L. 100–93, §3(c), substituted ''penalty, assessment, or exclusion'' for ''penalty or assessment'' in two places.

Subsec. (h). Pub. L. 100–93, §3(c), (e), substituted ''penalty, assessment, or exclusion'' for ''penalty or assessment'' in two places and inserted ''the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title),'' after ''professional organization,''.

Subsec. (i). Pub. L. 100–203, §4118(e)(8), as added by Pub. L. 100–360, §411(k)(10)(D), substituted ''this section'' for ''this subsection'' in introductory provisions.

Subsec. (i)(1). Pub. L. 100–203, §4118(e)(9), as added by Pub. L. 100–360, §411(k)(10)(D), inserted ''or subchapter XX of this chapter''.

Subsec. (i)(2). Pub. L. 100–203, §4118(e)(10)(B), as added by Pub. L. 100–360, §411(k)(10)(D), substituted ''for payments for items and services under subchapter V, XVIII, XIX, or XX of this chapter'' for ''submitted by—

''(A) a provider of services or other person, agency, or organization that furnishes an item or service under subchapter XVIII of this chapter, or

''(B) a person, agency, or organization that furnishes an item or service for which medical assistance is provided under subchapter XIX of this chapter, or

''(C) a person, agency, or organization that provides an item or service for which payment is made under subchapter V of this chapter or from an allotment to a State under such subchapter,

to the United States or a State agency, or agent thereof, for payment for health care services under subchapter XVIII or XIX of this chapter or for any item or service under subchapter V of this chapter''.

Subsec. (i)(5). Pub. L. 100–203, §4118(e)(10)(C), as added by Pub. L. 100–360, §411(k)(10)(D), and amended by Pub. L. 100–485, §608(d)(26)(J), added par. (5).

Subsecs. (j), (k). Pub. L. 100–93, §3(f), added subsecs. (j) and (k).

Subsec. (*l*). Pub. L. 100–203, §4118(e)(1)(B), as added by Pub. L. 100–360, §411(k)(10)(B)(ii)(III), added subsec. (*l*).

1986—Subsec. (a)(1). Pub. L. 99–509, §9313(c)(1)(B), substituted ''(i)(1)'' and ''(i)(2)'' for ''(h)(1)'' and ''(h)(2)'', respectively.

Subsec. (b). Pub. L. 99–509, §9313(c)(1)(D), (E), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (b) as (c) and substituted ''subsection (a) or (b)'' for ''subsection (a)'' in pars. (1) and (2). Former subsec. (c) redesignated (d).

Subsec. (c)(3). Pub. L. 99–509, §9317(a), added par. (3).

Subsec. (c)(4). Pub. L. 99–509, §9317(b), added par. (4).

Subsec. (d). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (c) as (d) and substituted ''subsection (a) or (b)'' for ''subsection (a)'' in introductory provisions. Former subsec. (d) redesignated (e).

Subsecs. (e), (f). Pub. L. 99–509, §9313(c)(1)(D), redesignated subsecs. (d) and (e) as (e) and (f), respectively. Former subsec. (f) redesignated (g).

Subsec. (g). Pub. L. 99–509, §9313(c)(1)(A), (C), (D), redesignated subsec. (f) as (g) and substituted ''subsection (a) or (b)'' for ''subsection (a)'' and ''subsection (e)'' for ''subsection (d)''. Former subsec. (g) redesignated (h).

Subsec. (h). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (g) as (h) and substituted ''subsection (a) or (b)'' for ''subsection (a)''. Former subsec. (h) redesignated (i).

Subsec. (i). Pub. L. 99–509, §9313(c)(1)(D), redesignated subsec. (h) as (i).

1984—Subsec. (a)(2)(C). Pub. L. 98–369, §2306(f)(1), added cl. (C).

Subsec. (g). Pub. L. 98–369, §2354(a)(3), substituted ''utilization and quality control peer review organization'' for ''Professional Standards Review Organization''.

1982—Subsec. (a). Pub. L. 97–248 redesignated as part of par. (1) preceding subpar. (A) provisions formerly preceding par. (1), in subpar. (B) substituted ''or pursuant to a determination by the Secretary under section 1395cc(b)(2) of this title with respect to which the Secretary has initiated termination proceedings;'' for ''or 1395cc(b)(2) of this title,'', and in par. (2) substituted ''presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged'' for ''is submitted in violation of an agreement between the person and the United States or a State agency''.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6408(a) of Pub. L. 111–148 applicable to acts committed on or after Jan. 1, 2010, see section 6408(d)(1) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–277, div. J, title V, §5201(d), Oct. 21, 1998, 112 Stat. 2681–917, provided that: ''The amendments made by this section [amending this section and section 1320a–7d of this title] shall take effect on the date of the enactment of this Act [Oct. 21, 1998].''

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997,

see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Section 4304(c) of Pub. L. 105–33 provided that:

''(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) [amending this section] shall apply to arrangements and contracts entered into after the date of the enactment of this Act [Aug. 5, 1997].

''(2) KICKBACKS.—The amendments made by subsection (b) [amending this section] shall apply to acts committed after the date of the enactment of this Act.''

Amendment by section 4331(e) of Pub. L. 105–33 effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, see section 4331(f) of Pub. L. 105–33, set out as a note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Section 231(i) of Pub. L. 104–191 provided that: ''The amendments made by this section [amending this section and sections 1320c–5 and 1395mm of this title] shall apply to acts or omissions occurring on or after January 1, 1997.''

Section 232(b) of Pub. L. 104–191 provided that: ''The amendment made by subsection (a) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Aug. 21, 1996].''

EFFECTIVE DATE OF 1989 AMENDMENT

Section 201(c) of Pub. L. 101–234 provided that: ''The provisions of this section [amending this section and sections 1320c–3, 1395h, 1395k, 1395*l*, 1395m, 1395n, 1395u, 1395w–2, 1395x, 1395y, 1395z, 1395aa, 1395bb, 1395cc, 1395mm, 1396a, 1396b, 1396d, and 1396n of this title, repealing section 1395w–3 of this title, and amending or repealing provisions set out as notes under sections 1320c–3, 1395b–1, 1395k, 1395m, 1395u, 1395x, 1395*ll*, and 1395ww of this title] shall take effect January 1, 1990.''

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(c)(2) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(e)(3), (k)(10)(B)(ii), (D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS

Section 4118(e)(14), formerly section 4118(e)(3), of Pub. L. 100–203, as renumbered and amended by Pub. L. 100–360, title IV, § 411(k)(10)(B)(i), (D), July 1, 1988, 102 Stat. 794, 795, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to activities occurring before, on, or after the date of the enactment of this Act [Dec. 22, 1987].''

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, except that amendment by section 3(a)(1) of Pub. L. 100–93 applicable to claims presented for services performed on or after date at end of fourteen-day period beginning Aug. 18, 1987, without regard to the date the physician's misrepresentation of fact was made, and amendment by section 3(f) of Pub. L. 100–93 effective Aug. 18, 1987, see section 15(a), (c)(3), and (d) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Section 9313(c)(2) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, § 4016, Dec. 22, 1987, 101 Stat. 1330–64; Pub. L. 101–239, title VI, § 6207(a), Dec. 19, 1989, 103 Stat. 2245, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to—

''(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act [Oct. 21, 1986], and

''(B) payments by eligible organizations or entities occurring on or after April 1, 1991.''

Section 9317(d)(1), (2) of Pub. L. 99–509 provided that: ''(1) The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 21, 1986], without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of nolo contendere tendered after the date of the enactment of this Act.

''(2) The amendment made by subsection (b) [amending this section] shall apply to failures or misconduct occurring on or after the date of the enactment of this Act.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(a)(3) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

REGULATIONS

Pub. L. 105–277, div. J, title V, § 5201(e), Oct. 21, 1998, 112 Stat. 2681–917, provided that: ''The Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, in order to implement the amendments made by this section [amending this section and section 1320a–7d of this title] in a timely manner.''

GAO STUDY AND REPORT ON IMPACT OF SAFE HARBOR ON MEDIGAP POLICIES

Pub. L. 105–277, div. J, title V, § 5201(b)(2), Oct. 21, 1998, 112 Stat. 2681–917, which provided that, if a permissible practice was promulgated under subsec. (n)(1)(A) of this section, the Comptroller General was to conduct a study comparing any disproportionate impact on specific issuers of medicare supplemental policies due to adverse selection in enrolling medicare ESRD beneficiaries before Aug. 21, 1996, and 1 year after the date of promulgation of such permissible practice under subsec. (n)(1)(A) of this section and was to submit a report to Congress on such study with recommendations concerning extension of the time limitation under subsec. (n)(1)(B), was repealed by Pub. L. 111–8, div. G, title I, § 1301(c), Mar. 11, 2009, 123 Stat. 829.

REPEAL OF 1988 EXPANSION OF MEDICARE PART B BENEFITS

Section 201(a) of Pub. L. 101–234 provided that:

''(1) GENERAL RULE.—Except as provided in paragraph (2), sections 201 through 208 of MCCA [sections 201 to 208 of Pub. L. 100–360, enacting section 1395w–3 of this title, amending this section and sections 1320c–3, 1395h, 1395k, 1395*l*, 1395m, 1395n, 1395u, 1395w–2, 1395x, 1395y, 1395z, 1395aa, 1395bb, 1395cc, 1395mm, 1396a, 1396b, and 1396n of this title, and enacting provisions set out as notes

under sections 1320c–3, 1395b–1, 1395k, 1395m, 1395u, 1395x, 1395*ll*, and 1395ww of this title] are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

''(2) EXCEPTION.—Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA [amending section 1395u of this title and enacting provisions set out as a note under section 1395u of this title.]''

STUDY AND REPORT ON INCENTIVE ARRANGEMENTS OFFERED TO PHYSICIANS

Section 9313(c)(3) of Pub. L. 99–509 directed Secretary of Health and Human Services to report to Congress, not later than Jan. 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians.

§ 1320a–7b. Criminal penalties for acts involving Federal health care programs

(a) Making or causing to be made false statements or representations

Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and ap-

Appendix C

(4) The officer reviewing the initial order (including the agency head reviewing an initial order) is, for the purposes of this chapter, termed the reviewing officer. The reviewing officer shall exercise all the decision-making power that the reviewing officer would have had to decide and enter the final order had the reviewing officer presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law or by the reviewing officer upon notice to all the parties. In reviewing findings of fact by presiding officers, the reviewing officers shall give due regard to the presiding officer's opportunity to observe the witnesses.

(5) The reviewing officer shall personally consider the whole record or such portions of it as may be cited by the parties.

(6) The reviewing officer shall afford each party an opportunity to present written argument and may afford each party an opportunity to present oral argument.

(7) The reviewing officer shall enter a final order disposing of the proceeding or remand the matter for further proceedings, with instructions to the presiding officer who entered the initial order. Upon remanding a matter, the reviewing officer shall order such temporary relief as is authorized and appropriate.

(8) A final order shall include, or incorporate by reference to the initial order, all matters required by RCW 34.05.461(3).

(9) The reviewing officer shall cause copies of the final order or order remanding the matter for further proceedings to be served upon each party.

Sec. 21. Section 421, chapter 288, Laws of 1988 and RCW 34.05.470 are each amended to read as follows:

(1) Within ten days of the service of a final order, any party may file a petition for reconsideration, stating the specific grounds upon which relief is requested. The place of filing and other procedures, if any, shall be specified by agency rule.

(2) No petition for reconsideration may stay the effectiveness of an order.

(3) If a petition for reconsideration is timely filed, and the petitioner has complied with the agency's procedural rules for reconsideration, if any, the time for filing a petition for judicial review does not commence until the agency disposes of the petition for reconsideration. The agency is deemed to have denied the petition for reconsideration if, within twenty days from the date the petition is filed, the agency does not either: (a) Dispose of the petition; or (b) serve the parties with a written notice specifying the date by which it will act on the petition.

(4) Unless the petition for reconsideration is deemed denied under subsection (3) of this section, the petition shall be disposed of by the same person or persons who entered the order, if reasonably available. The disposition shall be in the form of a written order denying the petition, granting

the petition and dissolving or modifying the final order, or granting the petition and setting the matter for further hearing. ((~~The petition shall be deemed to have been denied if not disposed of within twenty days.~~

~~(3) No petition for reconsideration may stay the effectiveness of an order.~~

~~(4) The agency head may extend the time limits in this section for good cause, with due consideration that the rights of the parties will not be prejudiced by the extension and that extension will be in the public interest.~~))

(5) The filing of a petition for reconsideration is not a prerequisite for seeking judicial review. An order denying reconsideration, or ((~~an extension of time limits pursuant to~~)) a notice provided for in subsection (((~~(4)~~))) (3)(b) of this section is not subject to judicial review.

Sec. 22. Section 422, chapter 288, Laws of 1988 and RCW 34.05.473 are each amended to read as follows:

(1) Unless a later date is stated in an order or a stay is granted, an order is effective when ((~~signed~~)) entered, but:

(a) A party may not be required to comply with a final order unless the party has been served with or has actual knowledge of the final order;

(b) A nonparty may not be required to comply with a final order unless the agency has made the final order available for public inspection and copying or the nonparty has actual knowledge of the final order;

(c) For purposes of determining time limits for further administrative procedure or for judicial review, the determinative date is the date of service of the order.

(2) Unless a later date is stated in the initial order or a stay is granted, the time when an initial order becomes a final order in accordance with RCW 34.05.461 is determined as follows:

(a) When the initial order is entered, if administrative review is unavailable; or

(b) When the agency head with such authority enters an order stating, after a petition for administrative review has been filed, that review will not be exercised.

(3) This section does not preclude an agency from taking immediate action to protect the public interest in accordance with RCW 34.05.479.

Sec. 23. Section 426, chapter 288, Laws of 1988 and RCW 34.05.485 are each amended to read as follows:

(1) If not specifically prohibited by law, the following persons may be designated as the presiding officer of a brief adjudicative proceeding:

(a) The agency head;

(b) One or more members of the agency head;

(c) One or more administrative law judges; or

(d) One or more other persons designated by the agency head.

HUNG DANG - FILING PRO SE

November 21, 2019 - 4:32 PM

Filing Petition for Review

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