

## Focus | Employee Benefits/Executive Compensation & Health Law

# Why Your Provider-Directed Subpoenas Aren't Working

BY KAYLEE HENSON AND RAY CLAPP

Texas law has long required that plaintiffs in tort actions or personal injury cases support their claims for medical expense from a defendant with evidence that the charges were reasonable and necessary. But things shifted after *In re N. Cypress Medical Center*, 559 S.W.3d 128 (Tex. 2018) and the line of cases that followed, as Texas courts clarified that, under certain limited circumstances, the amounts a third-party medical provider was willing to accept as payment from government/commercial payors could sometimes be relevant to the underlying damages dispute between a plaintiff and alleged tortfeasor.

Since then, third-party subpoenas directed to hospitals, clinics, and other health care providers have become a regular—and increasingly burdensome—feature of Texas litigation. High-volume personal injury lawyers and defense counsel routinely issue boilerplate subpoenas and deposition requests seeking medical and billing information from medical providers. However, these subpoenas often fail to meet patient privacy requirements and include

overbroad, unnecessarily complicated, and voluminous requests that providers are unable to answer. The result is mismatched expectations, delays, and escalating third-party motion practice that drain resources for litigants and providers alike.

Texas lawyers can streamline this process when they understand the requirements and needs of both sides. To get there, these subpoenas must overcome two common problems: missing HIPAA requirements and overbroad, burdensome document requests.

First, litigators must ensure their requests are HIPAA-compliant. Subpoenas for patient billing records often implicate protected health information (PHI), and providers are covered entities that must comply with state and federal privacy laws. Be prepared to identify the applicable exception to state and federal privacy laws that allow for production of any PHI, or ensure your subpoenas are accompanied by a valid authorization, statement of assurance, or court order authorizing production of any documents or information containing PHI.

Second, third-party billing subpoenas should be sufficiently tailored to allow the providers to respond with information that

they can reasonably provide and information that litigants can actually use. Lawyers often issue subpoenas demanding production of provider's confidential managed care contracts, chargemasters, rate sheets, and other reimbursement documents for multiple years, in addition to numerous other billing and reimbursement documents. The problem? These requests seek irrelevant information and are almost never proportional to the needs of the case. See, e.g., Tex. R. Civ. P. 192.4(b); Fed. R. Civ. P. 26(b)(1). Managed care contracts, for example, are not one-patient, one-service documents. They are voluminous, confidential contracts that often contain information about multiple insurance products, hundreds of services, and in a dialect only revenue-cycle specialists could love—CPT codes, HCPCS codes, reimbursement grids, and enough jargon to make even seasoned litigators squint.

Equally problematic are requests for “any and all” billing records, including internal notes, emails, and documentation of communication with payors. If a provider produced every document requested, the sheer volume would bury the issuing attorney in weeks of document review and likely require an expert to analyze. And the production of many of these billing documents raises important questions of competitive harm and confidentiality concerns, especially when the issuing litigant has made no effort to enter a protective order in the underlying case.

When a subpoena demands sweeping sets of confidential records, most providers simply do not have the capacity to respond with everything requested, so the requests inevitably get sent over to outside counsel, who must then negotiate the scope. This

turns into a familiar cycle of extensions, objections, and motion practice just to land on something workable. For this reason, issuing attorneys should consider narrowing their requests from the outset. Skip the overbroad requests and ask for more targeted information (e.g., confirmation whether a particular medical bill even has an amount due or the reimbursement the provider would expect from government or commercial payors for the actual services provided to the patient). Starting with these narrower types of requests allow the issuing counsel and third-party medical provider to more quickly evaluate what objections may exist and find a path forward.

Providers may be able to produce information responsive to narrower requests more quickly, in a user-friendly format like an agreed deposition upon written questions (DWQ), and without triggering overbreadth or burdensomeness concerns, allowing both sides to skip weeks—or even months—of negotiating to limit the requests. That gets issuing counsel the information he/she requires, in a format a vendor can produce, and without triggering an in-depth legal review process.

In sum, it is important to keep in mind that medical providers and the underlying litigants do not have to be adversaries in these third-party discovery disputes. They can work together to get the best result possible without hitting clients with expensive discovery disputes. Narrow, compliant requests that track the requirements of Texas law allow providers to produce usable information with fewer headaches for everyone involved.

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