



## Texas Legislature Convenes: Numerous Health Care Issues Arise

The Texas Legislature convened in January. While numerous issues face the State, health care will certainly see its share of bills filed. Among the various areas on which legislation will be introduced related to health care are:

1. Access to health care coverage. We are likely to see legislation filed requiring insurers in Texas to provide products that are more affordable and accessible. The exchange for such programs will be a narrowing of benefits, and an increased opportunity for smaller organizations and cooperatives to purchase insurance in groups. Also, as there is the appearance of added funds at the state level, there is certain to be a push for additional funding of the CHIPS program. Much of this legislation has already been filed; however, additional legislation creating pooling opportunities for the purchase of health insurance is expected soon.
2. Transparency and access to information. Transparency has become a buzz word in health care. Of late, we have seen numerous attempts by insurance companies to provide information to their patients and business insureds related to rating systems for health care providers. These attempts have been ununiformed and, in some cases, have led to inaccuracies that confuse and mislead patients. Specifically, Blue Cross/Blue Shield recently withdrew its rating system because of the belief that it was not providing accurate or helpful information. The Legislature is expected to address this transparency issue. Legislation has been introduced to create mandatory, uniform data collection and public reporting programs as well as cost comparisons. Additionally, there is legislation related to the reporting of medical errors and infection information.
3. Ambulatory care centers. There will again be issues related to physician-owned ambulatory care facilities. There will be a push for additional requirements of ownership disclosure by physicians to patients. Additionally, legislation is expected that will require all hospitals to provide emergency care.

Additional legislation will likely be filed related to the protection of patient information, electronic medical records, and directing proceeds from fines for bad driving habits towards trauma care and EMS providers.

The Legislature is just underway, and many of these issues are just beginning to see the initial drafts of legislation. The attorneys at Chamblee & Ryan will be monitoring the legislative process and those bills affecting our clients as they progress through the system. Please do not hesitate to contact our office to obtain information about pending legislation, and how such legislation will impact your practice.

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## The Legalities of Death Certificates in Texas

In the late 1800s, Josiah Charles Stamp, the First Baron of Short Lands, was quoted as saying:

“The government is very keen on amassing statistics. They collect them, add them, raise them to the  $n^{\text{th}}$  power, take the cube root and prepare wonderful diagrams. But you must never forget that every one of these figures comes in the first instance from the village watchman who just puts down what he damn well pleases.”

Today, vital statistics are obtained at numerous levels. In Texas, vital statistics are obtained by the Department of Health Services. The National Center for Health Statistics collects the information at a national level, and the World Health Organization collects the information at the international level. For information related to mortality, doctors and medical examiners are today’s village watchman. The information collected by these agencies and provided by the physicians and medical examiners are used to assess the health of the population, to set life expectancies, to allocate resources for medical treatment and research, and to determine risks and provide actuarial studies for the insurance industry. However, many questions arise as to what the physicians’ duties are relating to filling out death certificates, and the appropriate method of completing such death certificates.

Under Texas law, an attending physician shall complete the death certificate within five (5) days if the death occurred under medical attendance for care and treatment of a condition or disease process that contributed to the death. A doctor is excused from completing a death certificate if he or she is unavailable; the attending physician approves that someone else complete the death certificate, who has access to the deceased’s medical history; and the death is due to natural causes. A physician commits a Class C misdemeanor if he or she refuses or fails to fill out a death certificate. Additionally, it is a felony to knowingly or intentionally provide false information in a death certificate.

An inquest must be held by the medical examiner in the following situations: (1) if a person dies within 24 hours of admission to a hospital, other government institution, or a jail; (2) if the person is killed or dies from any unnatural cause; (3) if a body or body parts are found and the cause of death is unknown; (4) when the circumstances of death are such to lead to suspicion that the death was by unlawful means; (5) any suicide; (6) when the person dies without having been attended by a physician; (7) when the person is a child younger than six years old; and (8) **when the person has been attended immediately prior to death by a physician, but the physician is unable to certify with certainty the cause of such death.** The last provision provides an out for a physician anytime a physician is uncertain of the exact cause of death. However, it should be remembered that, under Texas law, a death certificate provides *prima facie* evidence of the facts stated on such record. Additionally, the cause of death stated in the death record will be heavily relied upon by a jury, if there is a subsequent claim by the family. Therefore, if the doctor is aware of the cause of death, it is most likely in the physician’s best interest to include the cause of death on the death certificate.

When preparing a death certificate, the physician must understand that the death certificate calls for an immediate cause of death. Following the blank for the immediate cause of death are blanks for sequential entries of events leading to the death. Each of these entries also provides an area for time intervals. Finally, there is a space for other significant conditions attributing to death but not causing the death. When completing the cause of death, the physician should attempt to enter information

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## CMS Requires Employers to Educate on False Claims Act

Section 6032 of Deficit Reduction Act of 2006 requires that health care entities receiving over \$5 million in Medicaid funds annually implement policies that describe the federal and state laws related to false claims, false statements, and whistle blower protection, as well as the entities' own policies and procedures related to avoiding fraud. The policies and procedures must include material related to employees, contractors, and agents. Additionally, the employee handbook must include a discussion of these anti-fraud and abuse policies.

A recent briefing by the CMS provided that the effective date for compliance with this new requirement was January 1, 2007. CMS does not require entities to hold training or education programs for employees on the anti-fraud and abuse policies; however, if such entities do not conduct training sessions, they must communicate and make accessible information related to such policies, and the employee handbook must include specific references to such policies. In particular, the CMS made clear that is not enough to make this information available to employees. Rather, the information must be published in the employees' handbook with a copy given to each employee.

There have been many questions raised about the extent to which information must be provided to contractors. It is still unclear exactly how information will need to be provided to contractors. However, the CMS made clear that providers

must inform their contractors who receive income from Medicare or the benefits of Medicare from the provider, of their anti-fraud and abuse policies and procedures, as well as state and federal law related to false claims. CMS indicated that there will not need to be changes made to agreements between agents and contractors to include references to such policies and procedures.

As to the specific content of the anti-fraud and abuse policies and procedures, they must describe the state and federal laws regarding false claims, false statements, and whistle blower protection. Additionally, the policies must have specific statements regarding the provider's own policies and procedures related to detecting and preventing fraud and abuse. While some states are promulgating a template summary for use by providers, Texas has not adopted such a template.

There is some debate as to within what structure the \$5 million threshold must be reached. On this issue, CMS recommends that any entity that is close to the \$5 million threshold act in compliance with the new requirements.

Chamblee & Ryan will be working to develop model policies and procedures outlining the federal requirements. Should you need assistance in preparing for this change in the law, please do not hesitate to contact one of our attorneys.

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that is constructed to depict the cause and effect as to the sequence of events leading to death. A physician should only list the underlying causes alone if there is no immediate cause of death that can be identified. A physician may be well served to use qualifiers in his or her description of the cause of death, including "probable" or "presumed."

It is the physician's job to identify the mechanism of death, not the mode of death. By way of example, "cardio pulmonary arrest" is an inappropriate entry on a death certificate. Rather, a correct entry would be: "cardiac arrhythmia - five minutes", as the immediate cause; "myocardial infarction - six days", as an intermediate cause; "hypertension - 20 years", as the sequence leading up to the death. For time intervals, a physician should use reasonable estimates or best clinical judgment. Old age is never an appropriate entry on a death certificate for cause of death. On a death certificate, a physician should never use medical abbreviations. Do not use number abbreviations for months. In addition, use military time rather than a.m. or p.m. A physician should make the printing legible. In addition, a physician should not leave blanks and should not delay in completing the death certificate. Effective January 1, 2006, Texas offers on-line death certificate completion. The form on-line is essentially the same as that filled out by the physician on hard copy.

Should you have any additional questions related to death certificates, please do not hesitate to call one of the attorneys at Chamblee & Ryan.



## Fifth Circuit Court of Appeals Holds There Is No Private Cause of Action Under HIPAA

On November 13, 2006, the United States Court of Appeals for the Fifth Circuit held that individuals cannot bring private causes of action against their health care providers for violations of the Health Insurance Portability and Accountability Act (HIPAA). See *Acara v. Banks*, 470 F.3d 569 (5th Cir. 2006). The Fifth Circuit is the first federal circuit to specifically make this determination.

In this case, Margaret Acara alleged that her doctor violated HIPAA's confidentiality provisions by failing to obtain her consent prior to disclosing her medical history during a deposition. HIPAA does not explicitly provide individuals with a private cause of action for improper disclosure of confidential medical information, so the Court reasoned that Ms. Acara could only prevail if such a right is "implied" by the statute. Even though HIPAA allows for civil and criminal penalties for improper disclosures, the Fifth Circuit noted that the statute only allows the Secretary of the Department of Health and Human Services to enforce such penalties. Therefore, the Court reasoned that Congress must have intended to prohibit private enforcement claims since it specifically delegated enforcement authority only to a governmental entity. This ruling will likely avoid numerous lawsuits by individuals against health care entities and providers for failure to comply with HIPAA.

## Employment Law Update: U.S. Supreme Court Redefines "Adverse Employment Action" for Purposes of Retaliation Claims

The United States Supreme Court's opinion in *Burlington Northern v. White* in 2006 serves as a reminder to physicians to be careful when dealing with employees who have made complaints of discrimination, harassment, or hostile work environment. As discussed below, the ruling will make it more difficult for you, as an employer, to obtain summary judgment, and therefore to avoid a trial, in certain types of retaliation cases. However, the issue of causation should remain the focus in defending any retaliation claim. *Burlington* has not changed that aspect of a retaliation claim.

In *Burlington*, the plaintiff made a complaint of sexual harassment at work. An investigation was made into her complaint, which resulted in her supervisor being disciplined. During this time, the plaintiff was assigned to forklift duties. However, after her initial complaint, she was assigned to perform standard track laborer tasks, which also fell within her job description. The plaintiff filed a retaliation complaint based on the reassignment. She was subsequently suspended without pay for insubordination. The employer later determined that she had not been insubordinate and reinstated her, with back pay for the days of the suspension. The plaintiff filed a second claim of retaliation regarding the suspension.

To maintain a claim for retaliation, the plaintiff must demonstrate that (1) she engaged in protected activity; (2) an adverse employment action occurred; and (3) a causal link exists between the protected activity and the adverse employment action. Up until this point in time, the federal appeal courts had differed on what actions constituted an "adverse employment action" in a retaliation case. Some courts required a change in compensation, terms, conditions, or employment opportunities. However, other courts allowed an "adverse employment action" to encompass any action that may dissuade an employee from enforcing his or her rights or reporting perceived acts of discrimination and harassment. The Court ruled that any act that can be construed to make an employee less likely to raise the initial complaint can be viewed as an "adverse employment action" in a retaliation claim. In this case, the Court held that a reasonable person could be dissuaded from making a complaint if he or she might be subjected to more difficult job assignments and a period of unpaid suspension, even if the employer was later paid for the time of suspension, because many reasonable employees would find a month without pay to be a serious hardship.

The *Burlington* ruling gives a broader definition of what may constitute an adverse employment action in a retaliation claim and makes it more difficult for you as an employer to obtain summary judgment in such a case because the employee has a greater chance of creating a fact issue in this respect since reasonable minds may differ on what changes in employment may dissuade a person from making a complaint. For this reason, the number of retaliation claims, especially in instances that do not involve terminations, is expected to rise substantially.

While the *Burlington* case discusses what may constitute an "adverse employment action," it is important for you as an employer to remember that this is only one element of a retaliation claim. An employee may make a complaint regarding alleged discrimination or harassment, but the mere fact that a complaint was made does not entitle an employee to protection from any changes in his or her job duties or make the employee immune from disciplinary action or termination for misconduct, poor work performance or a reduction in workforce. To effectively defend a retaliation case, you must be able to show that the employment action would have been taken even if the employee had not made the complaint.



For more information regarding Chamblee & Ryan's Health Law practice, please contact David Criss at 214-905-2003.