The Legal Doctor

Overviews of common legal issues

FMA

FLORIDA MEDICAL ASSOCIATION

INTRODUCTION

The articles in *The Legal Doctor* do not constitute legal advice and are presented for educational purposes only. The information contained in *The Legal Doctor* should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. The information presented in these articles is based upon current Florida and federal law and is subject to change based on changes in Florida and federal law. The FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Table of Contents

Accommodating Hearing-Impaired Patients
Ada And Treatment Of Hiv Infected Patients
Adverse Incident Reports
Advertising
Aids And Hiv
Balance Billing Of Hmo Patients
Balance Billing And Preferred Provider Organization
Canadian Drugs And Prescriptions
Child, Elder And Spousal Violence
Collection Of Deceased Patient's Bill
Collection Of Out-Of-State Debts
Communications Regarding Former Associates
Death Certificates
Deceased Physicians
Disclosure Of Medical Malpractice Liability Coverage
Disease Reporting Requirements
(Emtala) Provision Of Emergency On-Call Services By Physicians In Hospitals
End Of Life Care
Erisa-Insurers May Be Held Liable For Misrepresentation
Establishing A Physician Fee Schedule
Ethics Of Capitation
Expert Witness Fees
Family And Medical Leave Act Of 1993
Florida Patient's Bill Of Rights & Responsibilities
Gifts To Physicians From The Pharmaceutical Industry
Hmo Reimbursement For Emergency Care And Services
Hurricane Preparedness
Impaired Practitioners
Intractable Pain Statute
Limited English Proficient (Lep) Patients
Managed Care Contracts Things To Consider
Medical Assistants
Medical Care For Minors
Medical Clinic Registration
Medical Records

Medicare Contractual Options

Noncompetition Clauses

Opening Or Relocating Your Practice

Osha Requirements For A Medical Office

Paperwork Preparation Fee

Patient-Physician Relationship

Physician Collective Action

Physician Treatment Of Relatives

Political Involvement By Physicians

Pregnant Minors' Rights

Prescribing Standards Via Telemedicine

Prescription Renewals

Private Contracting And Medicare

Professional Courtesy

Professional Liability Insurance Requirements

Questions Commonly Asked By Physicians

Reporting Impaired Drivers

Retired Licenses And Limited Licenses

Retiring/Closing/Relocating A Practice

School Physicals

Statute Of Limitations For Medical Malpractice

Subpoena Compliance

Things To Consider Before Signing An Employment Contract

Unlicensed Activity

Volunteer Immunity

Workers’ Compensation: Certified Health Care Provider

Workers' Compensation & The Physician Businessman

FORMS:

Authorization For Use Or Disclosure
Of Protected Health Information

Consent To Treatment

Health Care Arbitration Agreement
Hiv And Aids Informed Consent Form

Letter From Physician To Attorney Who Has
Subpoenaed Medical Records

ACCOMMODATING HEARING-IMPAIRED PATIENTS

According to the Americans with Disabilities Act, which became law in 1990, a physician's office is considered a "public accommodation", and therefore must modify its policies and practices which discriminate or exclude disabled persons. 42 U.S.C. §12181(7); 28 CFR §36.104. Specifically, the ADA prohibits physicians from refusing to treat a hearing impaired person because of the handicap, and requires the physician to provide such auxiliary aids and services necessary "to communicate effectively with its customers, clients, patients or participants who have disabilities affecting hearing, vision, or speech." 56 Fed. Reg. 35553 (July 26, 1991). In addition, a physician may not charge the patient for the cost of providing such necessary aids and services. 28 CFR §36.301(c).

The law does not, however, absolutely require physicians to provide an interpreter for every hearing impaired person. The regulations adopted pursuant to the ADA require that a physician's office "furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities." 28 CFR §36.303(c). The communication must be as effective as communication with persons without a hearing impairment. The regulations define "auxiliary aids and services" to include qualified interpreters, notetakers, written materials or "other effective methods of making aurally delivered materials available to individuals with hearing impairments." 28 CFR §36.303(b)(1).

The comments to the ADA regulations make it clear that the auxiliary aid requirement is a flexible one. A physician is not required to hire a qualified interpreter in every case. A physician can choose among various alternatives "as long as the result is effective communication." The physician does not have to give primary consideration to the request of the person with the hearing impairment. The physician, however, should consult with the person before providing a specific auxiliary aid or service. This will allow the physician to make an independent determination as to what type of auxiliary aid is necessary. 56 FR 35544, 35567 (July 26, 1991).

Some situations (for example, lengthy or complex health matters, including major surgery) require the use of a qualified interpreter to ensure "effective communication." In addition, if the hearing-impaired patient does not understand English or cannot read and write, the use of an interpreter will be necessary to ensure "effective communication." Although the regulations do not define what constitutes lengthy or complex health matters, the ADA Title III Technical Assistance Manual provides several illustrations of situations where an interpreter may be required. For example:

ILLUSTRATION 1: H goes to his doctor for a bi-weekly check-up, during which the nurse records H's blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.

BUT: Upon experiencing symptoms of a mild stroke, H returns to his doctor for a thorough examination and battery of tests and requests that an interpreter be provided. H's doctor should arrange for the services of a qualified interpreter, as an interpreter is likely to be necessary for effective communication with H, given the length and complexity of the communication involved.

ILLUSTRATION 2: A patient who is deaf brings his own sign language interpreter for an office visit without prior consultation and bills the physician for the cost of the interpreter. The physician is not obligated to comply with the unilateral determination by the patient that an interpreter is necessary. The physician must be given an opportunity to consult with the patient and make an independent assessment of what type of auxiliary aid, if any, is necessary to ensure effective communication. If the patient believes that the physician's decision will not lead to effective communication, then the patient may challenge that decision under title III by initiating litigation or filing a complaint with the Department of Justice (see III-8.0000).

In those situations where an interpreter may be required, the physician must provide a qualified interpreter unless the physician can demonstrate that it would result in an "undue burden" on his or her practice. In other instances, depending on the facts of the particular case, the physician may use a notepad or a computer terminal to communicate with the person with the hearing impairment.

The regulations define "undue burden" to mean "significant difficulty or expense." 28 CFR §36.303(a). It is generally accepted that the cost of accommodating one or two hearing impaired patients does not constitute an undue burden of the physician, although a significant number of hearing impaired patients could place such a burden on the physician's practice. If the physician reasonably believes that the current volume of hearing impaired patients requiring interpreters significantly and negatively affects the practice, the physician may refuse further hearing impaired patients.

If an interpreter is required, the physician must ensure that the interpreter is qualified. An interpreter is "qualified" if the interpreter is one "who is able to interpret effectively, accurately and impartially, both receptively and expressly, using any necessary specialized vocabulary." 28 CFR §36.104. As a result, the physician may choose to use a nurse who is fluent in sign language instead of hiring an interpreter. In that case, however, the physician must ensure that the nurse is fluent in the same sign language used by the person with a hearing impairment. If not, the use of the nurse may not be considered to be "effective communication."

The ADA provides various means of enforcing the law. First, the law provides for private causes of action, including injunctive relief, by any person who is subjected to discrimination in violation of the ADA. 42 U.S.C. §12188(a)(1). The ADA also provides that the attorney general may investigate any potential violation of the ADA, and, if it has reasonable cause to believe that a violation has occurred, may bring a civil action in federal court. 42 U.S.C. §12188(b)(1). If the court finds that a violation of the ADA has occurred, it may grant injunctive relief, award monetary relief, and award a civil penalty in an amount not exceeding $50,000 for a first violation, and $100,000 for any subsequent violation. 42 U.S.C. §12188(b)(2). Finally, the ADA provides that the court may award the prevailing party attorney's fees and costs. 42 U.S.C. §12205.

To assist businesses with complying with the ADA, Section 44 of the IRS Code allows a tax credit for small businesses and Section 190 of the IRS Code allows a tax deduction for all businesses. The tax credit is available to businesses that have total revenues of $1,000,000.00 or less in the previous tax year or 30 or fewer full time employees. This credit can cover 50% of the eligible access expenditures in a year up to $10,250.00 (maximum credit of $5,000.00). The tax credit can be used to offset the cost of undertaking barrier removal and alterations to improve accessibility; providing accessible formats such as braille, large print or audiotape; making available a sign language interpreter or a reader for customers or employees, and for purchasing certain adaptive equipment. The tax deduction is available to all businesses with a maximum deduction of $15,000.00 per year. The tax deduction can be claimed for expenses incurred in barrier removal and alterations. To learn more about the tax credit and tax deduction provisions, access the IRS Webpage at www.usdoj.gov\crt\ada\taxcred.htm.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: December, 2009*

ADA AND TREATMENT OF HIV INFECTED PATIENTS

The decision of whether to treat an individual patient has traditionally been one left to the discretion of the individual physician. Federal legislation, however, has placed an obligation on physicians to treat certain types of individuals, most notably those individuals infected with HIV. As a result, physicians are torn between the desire to protect themselves and their staff, while simultaneously complying with federal antidiscrimination laws.

According to a U.S. Supreme Court decision, HIV infection is considered to be a disability under the Americans with Disabilities Act of 1990 (ADA), even though the infection has not progressed to the symptomatic stage. *Bragdon v. Abbott*, 524 U.S. 624 (1998). In that case, the Supreme Court held that HIV infection constitutes a physical impairment that substantially limits one or more of the major life activities of an individual. Notwithstanding its holding that HIV infection is a disability under the ADA, the Court held that the Petitioner dentist could have refused to treat the HIV infected patient if her infectious condition "pose[d] a direct threat to the health or safety of others." The Court held that the existence or nonexistence of a significant risk is determined from the standpoint of the health care professional who refuses treatment or accommodation, and the risk assessment is based on the medical or other "objective, scientific information available to him and others in his profession," not simply on his good-faith belief that a significant risk existed. *Bragdon*, at 624.

As a result, physicians may not discriminate against HIV infected individuals who wish to be treated by refusing to treat an HIV infected individual on the basis that the physician does not wish to treat such patients. Fortunately, the prohibition against discrimination does not necessarily mean every physician must treat every HIV/AIDS patient. For instance, it may be proper for an orthopedist with no training in infectious diseases to refuse to treat an HIV infected individual who does not have an orthopedic problem. In other words, it is arguable that a physician need not treat an HIV infected individual for a condition for which the physician has not been trained or is outside the physician's normal scope of practice.

On the other hand, a physician may not refuse to treat an HIV infected patient whose primary complaint concerns a condition which the provider normally treats. For instance, an ophthalmologist asked to provide a routine visual acuity exam would not be able to refuse treatment of an HIV infected patient on the basis of that individual's disease.

When in doubt, physicians should err on the side of treating on HIV infected individual, as the ADA's penalties can be quite severe.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

ADVERSE INCIDENT REPORTS

Florida law (Sections 458.351 and 459.026, Florida Statutes) requires that physicians report adverse incidents that occur in their offices. It is important that physicians understand the requirements of the statute before filing a report. Office adverse incident reports are public information (except for patient identifying information) and trigger an investigation of the physician by the Department of Health. Physicians should carefully read the definition of "adverse incident" prior to completing a report.

The law requires that adverse incidents that occur in an office maintained by a physician for the practice of medicine which are not licensed under Chapter 395 must be reported to the Department of Health. The report must be filed within 15 days of the occurrence and must be sent by certified mail. Physicians can be disciplined for failing to comply with these requirements.

Below are the components of what constitutes an adverse incident:

1. It is an incident over which the physician could exercise control. If the physician could not exercise control over the incident *it does not need to be reported.*

In addition, it must be:

2. an incident associated with a medical intervention, rather than the condition for which the intervention occurred.

In addition to the first two requirements,

3. the incident has to have resulted in one of the following:

a. death of the patient;

b. brain or spinal damage to the patient;

c. the performance of a surgical procedure on the wrong patient;

d. a procedure to remove unplanned foreign objects remaining from a surgical procedure;

e. a condition that required transfer of the patient; or

d. one of the following conditions *<u>if it resulted in</u>* death, brain or spinal damage, permanent disfigurement, fracture or dislocation of bones or joints or a limitation of neurological, physical or sensory function or transfer of the patient:

i. the performance of a wrong-site surgical procedure

ii. the performance of a wrong surgical procedure

iii. the surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient.

If 1, 2, and 3 are all met, then the incident should be reported to the DOH. Rule 64B8-9.001, Florida Administrative Code, sets forth the requirements for reporting the incident.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

ADVERTISING

According to Rule 64B8-11.001, Florida Administrative Code, the Florida Board of Medicine prohibits advertising which is false, deceptive or misleading. The Board of Medicine considers any advertisement which contains the following to be false, deceptive or misleading:

1. *A misrepresentation of fact or a partial disclosure of relevant facts;*
2. *False or unjustified expectations of beneficial assistance;*
3. *Any representation or claim which the physician does not expect to perform;*
4. *Statement or implication that the physician has received formal recognition as a specialist in an aspect of medical practice, unless the recognition has been received, and the recognized agency is approved by the Board of Medicine;*
5. *Representation that services can and will be competently performed for a stated fee when this is not the case;*
6. *Representation of fees for professional services that do not disclose all variables affecting the fees that will be charged;*
7. *The impression the physician possesses qualifications, skills or other attributes that are superior to other physicians, other than a simple listing of earned professional post-doctoral or other professional achievements recognized by the Board of Medicine;*
8. *Failure to conspicuously identify the physician by name in the advertisement;*
9. *Any representation that contains only a partial disclosure of relevant facts;*
10. *Includes reference to specialty certification without identifying the name of the specialty board that has awarded specialty certification.*
11. *Implies specialty or sub-specialty for which the physician has not received specialty recognition.*

Section 458.3312, Florida Statutes, provides that an allopathic physician “may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency approved by the Board. However, a physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician.”

However, Rule 64B8-11.001, F.A.C. provides that a physician may advertise a specialty received from a recognizing agency not approved by the Board only if the letterhead or advertising contains the following statement in the same print size or volume: “The specialty recognition identified herein has been received from a private organization not affiliated with or recognized by the Board of Medicine.”

For information on medical specialties approved by the American Board of Medical Specialties, call 1-866-275-2267.

It is the physician’s responsibility to maintain an exact copy of an audio or videotaped advertisement for a period of at least six months from the date that the actual advertisement is aired or shown.

Physicians who solicit patients personally or through an agent are responsible for any advertising used. A physician who advertises through referral services is likewise responsible and such advertisements are required to contain the following:

1. A statement that the advertisement is for a medical referral service and is in the behalf of the physician member of the service.
2. A statement that the referral services refers only to those physicians who have paid or been selected for membership in the referral service.
3. A statement that membership in the referral service is limited by the referral agency.
4. A statement that physicians who receive referrals from the service charge no more than their usual and customary fees.
5. These required statements shall be present in reasonably recognizable print or volume equivalent to the size or volume of other information in the advertisement.

In any advertisement for free, discounted or reduced fee services, examination or treatment, Section 456.062, Florida Statutes, requires that the following statement must appear in capital letters in a manner which is clearly distinguishable from the rest of the text:

THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT OF ANY OTHER SERVICE, EXAMINATION, OR TREATMENT WHICH IS PERFORMED AS A RESULT OF THE ADVERTISEMENT AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED OR REDUCED FEE SERVICE EXAMINATION OR TREATMENT.

"However, the required statement shall not be necessary as an accompaniment to an advertisement of a licensed health care practitioner defined by this section if the advertisement appears in a classified directory the primary purpose of which is to provide products and services at free, reduced, or discounted prices to consumers and in which the statement prominently appears in at least one place."

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

AIDS AND HIV

- Information regarding physician responsibilities with regards to AIDS is generally found in Chapters 381 and 384 of the Florida Statutes.

- A physician who makes a positive diagnosis of AIDS or HIV must report that information to the local county health department of the Department of Health. The information must be reported with sufficient specificity to identify the test subject and on the availability and location of sites at which anonymous testing is performed. Sections 381.004(3)(a) and 384.25(1), Florida Statutes; Rule 64D-3.030, Florida Administrative Code. All cases of AIDS and adult HIV must be reported within two weeks of the diagnosis. All cases of HIV in newborns and children below the age of six must be reported by the next business day. For the most up to date report form please look to Rule 64D-3.030(5) for more information. Indeterminate test results and unconfirmed positive antibody tests are not reportable.

- A minor (i.e., a person less than 18 years of age) may consent to treatment for a sexually transmissible disease, including AIDS. Section 384.30(1), Florida Statutes.

- There are several situations where informed consent for testing is not required including where there is (a) a bona fide medical emergency and the person is unable to consent; (b) a situation in which informed consent would be detrimental to patient and the test results are necessary to provide appropriate care or treatment; (c) a significant exposure has occurred during the course of employment or within the scope of practice of the physician, in which case the cost of the test must be borne by the physician; (d) a court order; or (e) a requirement in state or federal law requiring testing for sexually transmissible diseases, including testing of persons convicted of prostitution or of procuring another to commit prostitution. Section 381.004(2)(h), Florida Statutes.

- Informed consent is still required in all other cases and must include information on HIV infection reporting and on the availability of anonymous testing. Post-test counseling requirements have been revised to leave notification procedures to the individual medical practice. Nothing prohibits the results by telephone or mail; however, strict confidentiality provisions and penalties for violations require that physicians exercise extreme care in notifying test subjects of their results.

- The physician must confirm a positive HIV test before notifying the patient. Preliminary test results, however, may be released to health care providers and to the person tested when decisions about medical care or treatment of the person tested cannot await the results of confirmatory testing. Preliminary test results are defined to mean an antibody screening test, such as the enzyme-linked immunosorbent assays (ELISAs). Section 381.004(2)(d), Florida Statutes.

- A general release does not entitle a third party payor or any other individual to HIV records. A specific form for the release of HIV information as well as a HIV Informed Consent form can be found in the forms section of this document.

- No release is needed between health care providers consulting between themselves or with health care facilities to determine diagnosis and treatment. Section 381.004(2)(e)4, F.S.

- Health care workers involved in the delivery of a child can note the mother's HIV test results in the child's medical chart.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

BALANCE BILLING OF HMO PATIENTS

Section 641.3154, Florida Statutes, sets forth the rules governing the balance billing of a subscriber of a health maintenance organization (HMO). The basic rule is as follows: ***If an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.***

The key question then is when is the HMO **liable** for payment? Subsection (2) of the statute provides that an HMO is liable for services rendered to an eligible subscriber by a provider, if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization. The law creates a presumption that a provider *does not know and should not know* that an HMO is liable *unless*:

a. The provider is informed by the organization that it accepts liability;

b. A court of competent jurisdiction determines that the organization is liable;

c. The Agency for Health Care Administration (AHCA) make a final determination that the HMO is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel pursuant to Section 408.7056, Florida Statutes; or

d. AHCA issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to Section 408.7057, Florida Statutes.

The following examples will help explain the applicability of the balance billing statute:

1. If an HMO patient, in a non-emergency situation, knowingly goes out of network to a non-contracted physician for services that are covered by the HMO, and the physician is neither authorized by the HMO nor referred by the HMO, the physician may bill the patient directly for all charges.

2. If an HMO patient, in a non-emergency situation, knowingly goes out of network to a non-contracted physician for services that are not covered by the HMO, and the physician is neither authorized by the HMO nor referred by the HMO, the physician may bill the patient directly for all charges.

3. If an HMO, in a non-emergency situation, denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not considered a "covered service," and a contracted or non-contracted physician may bill the patient directly for all charges.

4. If an HMO, in a non-emergency situation, denies authorization for a service on the grounds that it is not a covered service, a contracted or non-contracted physician may bill the patient directly for all charges.

5. If a non-contracted physician does not seek authorization from the HMO for a service, and is not authorized or referred by the HMO, the physician may bill the patient for all charges.

6. If a non-contracted physician contacts the HMO and receives authorization for a covered service for an eligible subscriber the physician may not bill the patient and must accept whatever the HMO pays the physician as payment in full (minus any applicable co-payment).

The law further states, in subsection (4), that a provider or any representative of a provider, regardless of whether the provider is under contract with the HMO, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition also applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: June 2016*

BALANCE BILLING AND PREFERRED PROVIDER ORGANIZATIONS

Prior to 2016, the laws that regulated balance billing with regard to enrollees of health maintenance organizations (HMOs) did not apply to preferred provider organizations (PPOs) or exclusive provider organizations (EPOs). The basic rule in section 641.3154, Florida Statutes - *If an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider* – applied only in the HMO context. Physicians who did not participate in their patient's PPO or EPO were free to balance bill the patient when the insurance company did not pay the physician's full charge.

After a multi-year effort by consumer groups, insurance companies, the state consumer advocate's office, and a number of legislative leaders, the Florida legislature passed HB 221, which the Governor signed into law on April 14, 2016. This legislation, which goes into effect on July 1, 2016, provides that the PPO/EPO patient's insurance company is solely liable for paying a nonparticipating physician's fees (the patient can only be billed for applicable copayments, coinsurance, and deductibles) under the following circumstances:

a. For the provision of covered emergency services provided to an insured in accordance with the coverage terms of the health insurance policy; and

b. For the provision of covered nonemergency services provided in a facility that has a contract with the PPO/EPO and provided when the insured does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured.

In these two instances, the patient is only responsible for paying any applicable copayment, coinsurance, or deductible. The insurance company is responsible for paying the full amount otherwise due the physician, and must pay for services as specified in section 641.513(5). This statute provides that reimbursement for services shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided; or

(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

As with most new pieces of legislation, there are a number of questions that will wind up being resolved by the regulatory agencies or by the courts. An unanswered question is who determines what the "usual and customary provider charge" is and what method is to be used to make such determination. During negotiations on HB 221, the FMA sought first to require insurance companies to pay the full provider charge. After this approach was rejected by the legislature, the FMA next attempted to define "usual and customary" in a clearly objective way, not subject to interpretation by insurance companies. The preferred approach was to tie the amount of required reimbursement to a set percentile of the FairHealth Database. The legislature rejected this approach as well, and finally accepted compromise language that set reimbursement according to the ambiguous provisions of the HMO balance billing law. The key here is that, due to constant pressure from the FMA and its allies, the legislature also rejected language that would

have set the reimbursement amount at the physician's usual and customary **payment**, or the amount deemed **reasonable** by the insurance company. While the exact method of defining the "usual and customary charge" was not specified, it is clear that it is to be based on the physician's charges – not amounts paid by Medicaid, Medicare, other governmental payors, or pursuant to commercial participating provider agreements.

In practice, the physician will submit his/her bill for out-of-network services to the patients PPO/EPO plan. The insurance company will either: (1) determine that the billed amount reasonably represents the "usual and customary charge" for the particular service provided, and will pay the charge; or (2) will determine that the usual and customary charge is an amount lower than the billed charge, and will pay the lower amount.

In the instance where the physician believes that the insurance company has unfairly paid an amount less that the true usual and customary charge, the physician can attempt to negotiate a higher amount with the insurance company, can file a lawsuit in county or circuit court (depending on the amount at issue – circuit court jurisdiction is generally reserved for disputes in excess of $15,000), or can submit the matter to the "statewide provider and health plan claim dispute resolution program."

While anecdotal evidence suggests that physicians have eschewed the dispute resolution organization process in the past, changes were made to the statute in HB 221 that will hopefully make the process more physician friendly:

a. The resolution organization must review and consider all documentation submitted by both the health plan and the provider;
b. The resolution organization must make findings of fact in its recommendation;
c. The resolution organization must conduct an evidentiary hearing upon request of either party (costs to be equally shared);
d. The resolution organization may not communicate ex parte with either party;
e. The resolution organization's written recommendation must include how the organization calculated the amount due (which must be calculated under the provisions of s. 641.513(5)) and include any evidence relied upon; and
f. AHCA's final order is subject to judicial review pursuant to s. 120.68.

The FMA will work to ensure that AHCA requires the dispute resolution organization to calculate the amount due based on the plain wording of the applicable statute – that is, based on the usual and customary charge, not the usual and customary amount paid by the insurance companies to contracted providers. Any physician who believes that they have received an amount less than the usual and customary charge is encouraged to contact the FMA legal department at legal@flmedical.org.

Other Points to Note:

- The prohibition on billing the patient does not apply to the provision of "noncovered" services. Physicians are free to bill patients for the full amount of any service that is not covered by the patient's insurance company.

- A PPO/EPO plan must cover certain "emergency services" – "medical screening, examination, and evaluation by a physician . . . to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of the hospital." The PPO/EPO plan will always be solely responsible for the full payment (with the exception of copayments, coinsurance and deductibles) of all emergency services.

- For nonemergency services, the prohibition on balance billing the patient applies only when services are provided by a nonparticipating provider in a contracted facility (defined as a hospital, ambulatory surgical center, or urgent care center) and only when the patient does not have the ability and opportunity to choose a participating provider available to treat the patient. If the patient chooses the services of a nonparticipating provider knowing that a participating provider is present and available, the balance billing ban does not apply. If the noncontracted nonemergency services are provided in a facility that does not have a contract with the patient's PPO/EPO plan, the balance billing ban does not apply.

- The ban on balance billing does not apply to noncontracted services provided outside of a hospital, ambulatory surgical center, or urgent care center. If you provide noncontracted services to a PPO/EPO patient in your office, you can balance bill the patient, even if the services are provided as a follow up to emergency services provided in a hospital.

- HB 221 provides that it is grounds for discipline to fail to comply with s. 627.64194 (balance bill a PPO/EPO patient when prohibited) or s. 641.513. Such failure, however, must be **willful** and done with such frequency as to indicate a general business practice.

- If there is a dispute with the PPO/EPO plan over the proper usual and customary charge, the noncontracted physician can elect to resolve the dispute in a court of competent jurisdiction, or through the dispute resolution process mentioned above. This dispute resolution process is **voluntary**. A physician need not go through this process prior to filing a lawsuit.

- A noncontracted facility providing emergency services to a PPO/EPO patient may not balance bill the patient for any amount not covered by the patient's PPO /EPO plan.

If you have any questions related to balance billing of PPO/EPO patients please contact Jeff Scott at jscott@flmedical.org.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: June 2016*

CANADIAN DRUGS AND PRESCRIPTIONS

Canadian law does ***not*** allow a Canadian pharmacist to fill a prescription written by a physician licensed only in the United States. A Canadian physician must issue the prescription (in fact, the Canadian province may require that the physician be licensed in that province.)

Some Canadian physicians have been signing off en masse on U.S. issued prescriptions that are being brought into Canada to be filled, but Canadian medical authorities have started investigating the Canadian physicians who are doing this without adequate examination of the patient. While it is not illegal for a Florida physician to write a prescription that the patient is going to have filled in Canada, Florida physicians should refrain from giving any advice on the matter to their patients.

The following information regarding Canadian drugs comes from Jay Fisher, JD, Legislative Analyst with the American Academy of Orthopedic Surgery:

It is a violation of the Food, Drug and Cosmetic Act (21 USC) to import drugs into the United States from Canada by or for individual US consumers [21 USC]. The reason for this is that FDA approvals are "manufacturer-specific" and "product-specific," and they include many requirements relating to the drug including location, formulation, source and specifications of active ingredients, processing methods, manufacturing controls, container/closure systems and appearance. If a specific drug was originally manufactured in the US and then exported, it is permissible for it to be imported back to the States, but only if the importation is done by the US manufacturer [21 USC Section 381(d) (1)]. In the view of the FDA, virtually all shipments of prescription drugs imported from a Canadian pharmacy will run afoul of the Act. If parties are involved in violations of the Act, there are many potential avenues of liability. A court can enjoin violations of the Act. A person who violates the Act can also be held criminally liable. Those who can be found civilly and criminally liable under the Act include all who cause a prohibited act. Those who aid and abet a criminal violation of the Act, or conspire to violate the Act, can also be found criminally liable. FDA's "personal importation policy" is used in connection with importations of drugs by individuals for their personal use only. Under this policy, the Agency allows individuals and their physicians to bring into the United States small quantities of drugs sold abroad for the consumers' treatment for which effective medication is not available domestically. The Agency makes it very clear that its "personal importation policy" is not intended to allow importation of foreign versions of drugs that are already approved in the U.S. (FDA is apparently of the opinion that foreign versions of US-approved drugs are what Canadian pharmacies often sell to US consumers unbeknownst to them.) The Catch 22 situation, of course, is that if the drug is not a foreign version of a US drug (that is, it was manufactured in the US according to FDA guidelines and then exported), under the Food, Drug and Cosmetic Act it can only be imported back by the original manufacturer; that is, not an individual or a doctor. See above. FDA has further emphasized that its policy is not something that is formally permitted under federal law; it's simply a matter of "enforcement discretion." While the Agency acknowledges it has not often prosecuted individuals and providers importing illegal drugs into the US from Canada, it reserves the right to do so if it so chooses.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: December 2009*

CHILD, ELDER AND SPOUSAL VIOLENCE

With the issue of domestic violence receiving headlines over the past several years, there has been renewed interest in the obligations of a physician to report suspected and known cases of domestic violence. Fortunately, Florida law is explicit with regard to the obligations of a physician to report suspected domestic violence, although the laws do differ with regard to child abuse, spousal abuse and elder abuse. The one common theme, however, is that virtually any known abuse must be reported to the appropriate authorities.

With regard to child and elder abuse, the laws are virtually identical. Sections 39.201(1) and 415.1034, Florida Statutes, state that any physician "who knows or has reasonable cause to suspect" that a child or elderly person is abused, abandoned or neglected must report this fact to the Department of Health (for purposes of defining an elderly person, the statute refers to those of age 60 or older). The report must be made to the department's central abuse hotline on the single statewide toll-free telephone number 1-800-962-2873. It should also be noted that the physician's name will be held confidential and will not be given to the accused. Sections 415.107(1) and 39.201, F.S. The physician's name may only be used by department employees actually involved in the investigation, law enforcement agencies, and the state's attorney's office. Sections 415.107 and 39.202, F.S.

Similarly, any physician required to report or investigate cases of suspected child abuse, abandonment, or neglect who has reasonable cause to suspect that a child died as a result of the above shall report his or her suspicion to the appropriate medical examiner. Section 39.201(3), F.S.

With regard to the elderly, "*abuse*" is defined to mean "any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health." "*Neglect*" is defined to mean "the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of a vulnerable adult. Section 415.102, F.S.

With regards to children, "abuse" is defined by Section 39.01(2), F.S., to mean "any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired." "Neglect" is defined by Section 39.01(47), F.S., as occurring "when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired." Finally, Section 39.01(1), F.S., defines "abandoned" to mean "a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver responsible for the child's welfare, while being able, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligations."

With regard to spousal abuse, there is no statute which directly requires a physician to report suspected spousal abuse. Nevertheless, Section 790.24, F.S., requires a physician who <u>knowingly</u> treats "a gunshot wound or life-threatening injury indicating an act of violence" to report the wound to the local sheriff. Significance must be attached to the use of the word "knowingly" in this statute, as it requires a physician to have actual knowledge of the violence, as opposed to having a mere suspicion. In addition, the physician must be treating the wound resulting from the violence, and may not report a wound discovered during treatment for another ailment. Should the physician knowingly treat such a wound, the physician is obligated to report this fact to the sheriff's department.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

COLLECTION OF DECEASED PATIENT'S BILLS

Contrary to a popular misconception, a person's debts do survive that person's death. Nevertheless, many physicians find it difficult to collect the debts owed by deceased patients, not knowing whether the insurance company, decedent's estate, or spouse is liable for the unpaid bills. Fortunately, to varying degrees, all three may be sources of recovery by the physician.

Although obtaining payment directly from the health insurer is the preferable method of receiving payment, several health insurers expressly forbid any assignment of benefits to non-network providers as a method of inducing network participation. Nevertheless, a physician should ask patients to assign benefits directly to the provider. By doing so, the physician, to the extent allowed by the patient's health insurance contract, will receive payment directly from the insurer. Moreover, even if the insurer does not accept assignment, the executed form could be useful in determining the intentions of the patient at a later date.

To the extent, however, that the insurer does not accept assignment or does not pay the full charge, the physician is entitled to payment by the patient's estate. To file a claim against the estate, a physician must file the claim in the county in which the patient was domiciled no later than three months after the estate publishes its Notice of Administration or thirty days after receiving direct notification from the estate. As creditors' claims must be satisfied before any of the estate's assets pass to the heirs, a physician's claim will be paid if it is proper and the estate has sufficient assets.

If the estate's assets are insufficient, the physician may wish to seek recovery from the patient's spouse. Historically, a husband was responsible for his wife’s necessary debts, such as medical bills, regardless of whether he had contracted for such liability. Under this common law doctrine, however, a wife was not similarly responsible for her husband’s necessaries unless she had specifically assumed such responsibility via a written instrument. This inequality led the Supreme Court to abrogate the doctrine of necessaries and rule that neither husband nor wife are responsible for the debts of the other. Connor v. Southwest Florida Regional Medical Ctr., Inc., 668 So.2d 175 (Fla. 1995). Liability is still present, however, where one spouse has expressly obligated himself/herself for the other’s debt. It should also be noted that the physician may also be able to recover from either spouse if that spouse has been "unjustly enriched" by receiving insurance proceeds which the spouse has not forwarded to the provider.

Unfortunately, most of these recovery techniques require legal intervention. Therefore, in order to avoid such legal entanglements, it is recommended that the physician obtain an assignment of any insurance proceeds.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

COLLECTION OF OUT-OF-STATE DEBTS

For many physicians the collection of debts from patients is one of the most tedious and difficult portions of practicing medicine. Unfortunately, the difficulty of collecting payment for services is compounded when the patient is only visiting the state of Florida, and has insurance from another state. In these instances, payments for services frequently are sent directly to the patient, notwithstanding a valid assignment executed by the patient in the physician's office.

Unfortunately, the laws of many states, including Florida, do not require an insurance company to honor an otherwise valid assignment of benefits. In fact, many insurance companies refuse to honor any assignment benefiting a physician who is not a member of the insurance company's preferred provider panel; this practice is used to coerce physicians into joining otherwise unattractive panels. As a result, the physician has limited options when attempting to ensure that adequate payment is received for services provided to out-of-state patients.

The first, and most obvious, option is to require payment in full at the time of service in all nonemergency situations. Only in this manner may the physician be assured of receiving full compensation. The second option, which is less effective, is to obtain an assignment from the patient, although the physician must be cognizant of the possibility that the assignment will not be honored and that payment will instead be made directly to the patient, who may not forward such payment to the physician. If neither of these techniques are successful, the physician may institute collection proceedings, although federal law makes it difficult to sue an out-of-state debtor for small amounts due to the jurisdiction requirements of the federal courts. Because of the inherent difficulties of obtaining payment after the time of services of out-of-state patients, it is recommended that physicians attempt to receive payment at the time of service from out-of-state patients.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: October 2005*

COMMUNICATIONS REGARDING FORMER ASSOCIATES

The departure of a physician from a practice, even under the best of circumstances, is extremely disruptive to patients and other physicians. Not only must notices be provided and accounts settled, but the practice must also determine the best way in which to inform the departing physician's patients of the change in personnel.

Florida law does not require the remaining members of the practice to refer patients to the departing physician. Nevertheless, several legal and ethical tenets make it advisable for the remaining members of the practice to ensure that inquiring patients receive accurate information as to the whereabouts of the departing physician. The first of these ethical tenets is the principle that a patient is entitled to be treated by the physician of their choice. *Opinion 9.06, AMA Council on Ethical and Judicial Affairs*. For this reason, unless a noncompete clause has been signed by the practice and the departing physician, the practice should facilitate the ability of the patient to maintain a relationship with their preferred provider. It is unethical for the practice to withhold information concerning the physician's new address upon request of the patient. *Opinion 7.03, AMA CEJA*. Secondly, the failure of the practice to accurately relay information regarding the departing physician's location may result in legal action against the practice. For instance, while the practice has no legal duty to state where the departing physician may be located, the practice could be liable under the doctrines of slander and tortious interference with business relationships if they provide false information. Commonly, a practice will state that a physician has left the practice and moved out of the area, even if the practice is aware that the departing physician remains accessible to the patient. Such a prevarication contains all the necessary attributes to a slander suit, to wit, a known falsehood coupled with damages to the offending physician. In the instance provided, the falsehood is the misrepresentation regarding the departing physician's location, and the damages are the amount lost by the departing physician, which would have been obtained through the continued relationship with the patient.

For the above reasons, practices should provide honest information when asked for the whereabouts of a departing physician. Nevertheless, business considerations understandably make such practices reluctant to provide free advertising for a new competitor. In this scenario, it is proper for a practice to state that a physician has departed from the practice, and the care of the patient may now be assumed by the remaining members of the practice. In other words, no information must be volunteered, although any information given must be accurate. Of course, if the patient specifically requests the address of the departed physician, and the practice knows the address, the practice must inform the patient of the physician's new address. In addition, if the patient's needs require the unique expertise of the departing physician, AMA policy dictates that the needs of the patient must come before the financial health of the practice.

Overall, appropriate behavior of a practice when responding to patients requesting the address or phone number of a former associate should be determined in the initial employment agreement, as it is customary in such agreements to provide for the terms of the employee's termination, including such items as noncompete clauses. If such precautions have not been taken, however, the practice must provide only accurate information regarding the departing physician, even if such information is minimal, and that information necessary to protect the health of the patient.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.
Last Update: December 2009

DEATH CERTIFICATES

After the death of a patient, the medical examiner will often contact the patient's physician and ask him to sign the death certificate. Whether or not the physician is responsible for doing so depends on the circumstances surrounding the death. Section 382.008(3), Florida Statutes, provides that "within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending physician or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending physician or medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief." It is important to note that the term "primary or attending physician" means a physician who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

Therefore, physicians who neither were in attendance at the time of the patient's death nor treated the decedent immediately prior to death are not required to sign the death certificate. In such cases Florida law provides that the medical examiner is the responsible party for signing the death certificate.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

DECEASED PHYSICIANS

The executor, administrator, personal representative or survivor of the deceased physician must retain medical records for at least two years from the physician's death. Section 456.057, Florida Statutes; Rule 64B8-10.001, Florida Administrative Code. Within one month of the physician's death, such a person must publish, in the newspaper of greatest general circulation in the county where the physician resided, a notice indicating to the deceased physician's patients that their medical records are available from a specific person at a specific location. Rule 64B8-10.001(2), Florida Administrative Code. A copy of this notice shall also be submitted to the Board of Medicine within one (1) month from the date of death of the physician.

After 22 months from the date of the physician's death, such person must publish once during each week for four consecutive weeks in the newspaper with the largest general circulation in the county where the physician resided a notice indicating to the patients of the deceased physician that the patient's medical records will be disposed of or destroyed one month from the last day of the fourth week of publishing the notice. Rule 64B8-10.001(3), Florida Administrative Code.

It is important to note that the physician must take proactive measures to ensure that their executor, administrator, personal representative or survivor have access to both paper and electronic medical records – this includes passwords for medical records maintained in an electronic format.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: August 2016

Disclosure of Medical Malpractice Liability Coverage

Florida law requires a physician to disclose to a plaintiff/claimant, upon written request, the name of each of the physician's insurers as well as the amount of coverage each insurer provides. The physician is also required to forward such request to all affected insurers. See § 627.4137, Fla. Stat.

This requirement works in tandem with the insurer's legal obligation to provide certain information to the plaintiff/claimant. An insurer who provides liability insurance coverage is required, upon written request by the claimant, to provide under oath: the name of the insurer; the name of each insured; the limits of the liability coverage; a statement of any policy or coverage defense which the insurer reasonably believes is available to the insurer at the time of filing such statement; and, a copy of the policy. The insurer must provide this information within 30 days of the claimant's written request.

Physicians should be mindful of whether his or her insurer has provided the documentation to the plaintiff/claimant. If the insurer fails to provide the above documentation, upon request of the plaintiff/claimant, it can cause complications when the case is ultimately resolved. Specifically, courts have overturned settlements where the insurer has failed to provide the above documentation to the plaintiff/claimant. Courts take the above obligation seriously and have recognized the importance of this information to a plaintiff/claimant in a suit against the insurer.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: December 2009*

DISEASE REPORTING REQUIREMENTS

Florida Administrative Code (FAC) Rule Chapter 64D-3 contains the Department of Health rules concerning control of communicable diseases and conditions that may significantly affect public health.

Rule 64D-3.029, FAC, provides that a number of human diseases and conditions are required to be reported to the local county health department. The Department of Health has listed the diseases and conditions as set forth in the rule as dangerous to the public health and requires that they be reported to the local county health department within the time frame outlined in the Table of Notifiable Diseases or Conditions in Rule 64D-3.029, FAC.

Rule 64D-3.030, FAC, provides the reporting requirements for physicians for all the diseases or conditions listed in the Table of Notifiable Diseases or Conditions in Rule 64D-3.029, FAC. Any physician who diagnoses, treats, or suspects a case, or who suspects an occurrence of a disease or condition listed in the table must report, or cause to be reported, the diagnoses or suspicions according to the procedures set forth in the rule. Any report of a notifiable disease or condition, except for cancer and HIV/AIDS must be reported on the Florida Department of Health Disease Report Form (DH Form 2136, 3/06). The form must include the patient's name, address, telephone number, date of birth, ethnicity, social security number, sex, date of onset of each case and the diagnosis. It is important to note that each physician who makes a diagnosis of or treats a notifiable disease or condition must make their patient medical records for the diagnosis or condition available for on-site inspection by the Department or its authorized representatives. All cases of HIV or AIDS must be reported on the Adult HIV/AIDS Confidential Case Report, CDC 50.42A Rev. 01/2003. All cases of HIV exposed newborns must be reported on the Pediatric Confidential Case Report, CDC 50.42B Rev. 01/2003. The forms are available from the county health departments or from the Department of Health.

There is a helpful poster that lists which diseases must be reported to the county health department along with the reporting timeframe and other helpful information available on the Department of Health's website under Practitioner List of Reportable Diseases at:

http://www.doh.state.fl.us/disease_ctrl/epi/topics/surv.htm

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

(EMTALA) Provision of Emergency On-Call Services by Physicians in Hospitals

The Office of the General Counsel often receives questions from physicians regarding whether Florida law requires that specialty physicians be available 24 hours a day, seven days a week to provide emergency services and care in a hospital emergency room. 42 U.S.C. §1395dd (EMTALA), Section 395.1041, Florida Statutes, the "Access to Emergency Services and Care Act," and Rule 59A-3.255, Florida Administrative Code, which implements the provisions of Section 395.1041, F.S., govern this area. These authorities do not provide that the only way that hospitals can ensure a service is provided in an emergency room 24 hours a day, seven days a week is by requiring physicians to be on-call 24 hours a day, seven days a week. Florida law also provides that hospitals can comply with their statutory obligation by entering into arrangements with other hospitals or physicians, or by requesting a service exemption from the Agency for Health Care Administration ("AHCA").

Section 395.1041(3)(d), F.S., requires that all hospitals must ensure the provision of emergency services within the service capability of the hospital "at all times, either directly or indirectly." "Service capability" is defined by Section 395.002(26), F.S., to mean "all services offered by the facility where identification of services offered is evidenced by the appearance of the service in a patient's medical record or itemized bill." In addition, Rule 59A-3.207, F.A.C., requires that every hospital offering emergency services and care must provide emergency care within the hospital's service capability 24 hours a day, seven days a week." As such, as long as a service falls under the definition of "service capability," a hospital is required to ensure that the service is available "either directly or indirectly" 24 hours a day, seven days a week.

Neither Section 395.1041(3)(d), F.S., nor Rule 59A-3.255, F.A.C., require that a hospital must provide emergency services and care for all services within its service capability at all times by requiring physicians to be available 24 hours a day, seven days a week. The statute and rule provide that a hospital must comply with Section 395.1041(3)(d), F.S., either directly or indirectly, through:

1. An agreement with another hospital made prior to receipt of a patient in need of the services; or
2. An agreement with one or more physicians made prior to receipt of a patient in need of the services; or
3. Any other arrangement made prior to receipt of a patient in need of the service.

In addition both the governing statute and the rule provide that, if a hospital determines that it cannot provide a service 24 hours a day, seven days a week, or that it cannot continue to provide a service 24 hours a day, seven days a week because of a significant change in circumstances, either through an arrangement with another hospital or with other physicians, it must request a service exemption from AHCA.

Before 2003, CMS reportedly used an undocumented informal 3-physician "rule of thumb" which requires a hospital to ensure that it has 24 hour on-call coverage for any specialty for which it has three or more physicians. If fewer than three were on staff, then full-time coverage was not required. Under this rule, a hospital which has only one or two specialists in a given area could have less than full coverage for that specialty without being considered to be in violation of EMTALA requirements.

The 2003 regulations expressly decline to follow a numerical approach, instead stating that CMS will consider "all relevant factors" in determining whether a hospital is in compliance with EMTALA requirements in maintaining its call list. The new regulations do not require 24-hour coverage for

under-represented specialties when that is not feasible, they permit physicians to serve on call at more than one hospital simultaneously, and they permit the ER to direct the patient to the specialist, such as to his office or another hospital where he is working, to see and examine the patient. The regulations require that hospitals develop protocols for handling specialty needs when its specialists are not available on call.

Section 395.1041(3)(d)3., F.S., and Rule 59A-3.255(4), F.A.C., govern the process for requesting a service exemption from AHCA. Section 395.1041(3)(d)3., F.S., provides, in pertinent part, that:

> A hospital shall not be required to ensure service capability at all times as required in subparagraph 1. if, prior to the receiving of any patient needing such service capability, such hospital has demonstrated to the agency that it lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the agency shall consider factors relevant to the particular case, including the following:
>
> a. Number and proximity of hospitals with the same service capability.
>
> b. Number, type, credentials, and privileges of specialists.
>
> c. Frequency of procedures.
>
> d. Size of hospital.

Rule 59A-3.255(4), F.A.C., provides that if a hospital submits a request for exemption, it must submit an application to AHCA identifying the service for which the hospital is requesting the exemption. AHCA has prescribed a form for submission of the exemption request, which is available form AHCA. AHCA is required to make a determination of exemption status and notify the hospital of the determination within 45 days of receipt of the request.

Accordingly, Florida law does not provide that the only way that hospitals can ensure that a service is provided 24 hours a day, seven days a week is by requiring physicians who practice that service to be on-call 24 hours a day, seven days a week. Florida law also provides that hospitals can comply with their statutory obligation by entering into arrangements with other hospitals or physicians, or by requesting a service exemption from AHCA. More importantly, if a hospital has been providing 24 hour a day, seven day a week coverage for a service through an arrangement with physicians, and the circumstances at the hospital significantly change such that the hospital cannot provide coverage 24 hours a day, seven days a week for the service, the hospital is required to request a service exemption through the process described above.

As a result, if the number of physicians available to cover a specific service change such that it is no longer practicable for the remaining physicians to provide coverage 24 hours a day, seven days a week, the hospital must either enter into a transfer arrangement with another hospital or request a service exemption from AHCA.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: December 2009*

END OF LIFE CARE

Below is a summary of the Florida Statutes relating to end of life care.

I. Do not resuscitate orders (Section 401.45)

   A. Health care providers may withdraw or withhold resuscitation from a patient if DNR order is presented

   B. Must be on State form

   C. Must be signed by patient, surrogate, proxy, court ordered healthcare guardian or person holding durable power of attorney with authority to make health care decisions

   D. Immunity from criminal prosecution or civil liability for complying with DNRO

II. Advance Directives in general (Sections 765.101-.113)

   A. Stated legislative intent is that adults have the right to make decisions regarding their care including the right to refuse care

   B. Decisions of a surrogate can be challenged on an expedited basis by a family member or the attending physician

   C. Existence of an advance directive cannot affect a person's life insurance or ability to get life insurance and cannot be a condition for receiving life or health insurance or health care services

   D. Immunity from criminal prosecution or civil liability for facility, provider or surrogate

   E. Facility has to provide each patient their rights regarding advance directives and a copy of the facility's policies

   F. A provider or facility that objects to a patient's advance directive may transfer a patient to another provider or facility - provider/facility is not required to act against their moral or ethical beliefs

   G. Felony charges for either concealing or forging an advance directive

   H. Certain medical procedures (abortion, electroshock, psychosurgery) must be expressly approved by patient or by a court

III. Health Care Surrogate (Sections 765.201-.205)

   A. Designation must be signed in the presence of two witnesses

   B. Document remains in effect until revoked

   C. Surrogate's authority kicks in if/when physician concludes (and enters conclusion in the medical record) that the patient does not have the capacity to make health care decisions

   D. If in doubt, the physician may have a second physician review the matter

   E. Surrogate may review medical records and make health care decisions

F. If there is no indication of what the patient would have chosen, the surrogate may consider the patient's best interest in deciding that treatments are to be withheld or withdrawn

IV. Life-Prolonging Procedures (Sections 765.301-.309)

A. A person may make a living will to direct the providing, withholding or withdrawal of life-prolonging procedures in the event of a terminal condition, an end-stage condition or a persistent vegetative state

B. Definitions of each of these are provided in the statute

C. Definition of end state condition has been changed to mean an <u>irreversible</u> condition that is <u>progressively</u> severe- requirement that there be an indication of incapacity and complete physical dependency has been dropped and ineffectiveness of treatment must be a medical <u>probability</u> instead of a medical certainty

D. Living will must be in writing and be signed by two witnesses

E. It is the patient's or surrogate's responsibility to ensure the attending or treating physician is notified

F. Once notified, the physician must make the living will a part of the patient's medical records

G. If no surrogate is appointed, a physician may simply comply with living will

H. If anyone disputes a physician's decision to withhold life-prolonging procedures, the physician shall not withhold. But if review of the decision is not sought within 7 days, the physician may proceed.

I. Before complying with a living will, the physician must determine that:

1. Patient does not have a reasonable medical probability of recovering capacity to make decision about care

2. The patient has a terminal condition, end-stage condition or is in a persistent vegetative state

J. If there is no living will:

1. Health care surrogate may make decision

2. Surrogate must conclude that:

i. patient does not have a reasonable medical probability of recovering capacity to make decision about care
ii. the patient has a terminal condition, end-stage condition or is in a persistent vegetative state

K. Determinations re: terminal condition, end-stage condition, or persistent vegetative state, and chances at recovery must be made by attending/treating physician and at least one other physician. Determinations go into the medical record.

L. Euthanasia not allowed, only withholding of care

V. Absence of Advance Directive (Sections 765.401-.404)

A. If no advance directive, the following persons may make health care decisions for an incapacitated patient (in the following order):

1. court appointed guardian
2. spouse
3. adult child or children
4. parent
5. adult sibling or siblings
6. adult relative who has exhibited special care and concern for the patient
7. close friend

B. Proxy must act according to how he believes the patient would have acted

C. If patient is in a persistent vegetative state and has left no indication of how they would like to proceed, the physician and a guardian may consult with the medical ethics committee of the facility and may withhold or withdraw life-prolonging procedures

D. If there is no indication of what the patient would have chosen, the proxy may consider the patient's best interest in deciding that treatments are to be withheld or withdrawn

VI. Pain Management

A. Section 765.1103 - "Pain management and palliative care"

1. A physician or his designee must give a patient information regarding pain management and palliative care

2. A facility or health care provider MUST comply with a request for pain management or palliative care

B. Section 458.326 - "Intractable pain; authorized treatment"

1. Physician may prescribe controlled substances for persons with intractable pain, so long as it is done within the standard of care

C. Board of Medicine rule - "Standards for the Use of Controlled Substances for Treatment of Pain"

1. Board to judge validity of prescribing based on documentation and individual circumstances, not on the quantities prescribed

2. Physician must be diligent in preventing diversion of drugs

3. Physician must document need for prescriptions

4. Guidelines given re: evaluating patient, treatment plans, consent, consultations and maintenance of medical records

---

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: October 2005*

ERISA-INSURERS MAY BE HELD LIABLE FOR MISREPRESENTATION

A frequent source of frustration to health care providers occurs when a provider receives approval for a service from an insurer, provides the service, but then receives notification from the insurer that the plan contract actually did not authorize such treatment. Under a longstanding law, the insurers were not held liable for such a misrepresentation, arguing that the Employee Retirement Income Security Act (ERISA) forbids oral modification of plan terms Nachwalter v. Christie, 805 F.2d 956, 959 (11th Cir. 1986). As a result, courts held that misstatements of plan terms uttered by representatives of an insurance carrier could not bind the insurance company to pay for such services.

Fortunately, case law in the U.S. Court of Appeals 11th Circuit has chipped away at the insurer's "ERISA" defense. In Lordmann Enterprises, Inc. v. Ecquicor, Inc. 32 F.3d 1529 (11th Cir. 1994), the Court held that an insurer administering an ERISA plan may be held liable for "negligent misrepresentation". As a result of this decision, if a provider can prove that the insurance carrier was negligent when it provided its misrepresentation of the ERISA plan coverage of a service, the provider may hold the insurer liable for the resulting damages. Moreover, the court reaffirmed previous law which "recognized a cause of action for equitable estoppel when a plan administrator makes a representation that interprets, rather than modifies, an ambiguous term of the plan."

These rulings may provide assistance to physicians who are faced with two common dilemmas. In the first, the provider receives authorization for services, as the insurer affirms that the patient is covered by the plan, only to be told at a later date that the patient's coverage had terminated prior to the authorization, and that no payment will be made for the services. As a result of the Lordmann decision, however, the insurance company may still be held liable if it can be shown that the representative should have known that the coverage had lapsed. In the second example, a provider receives authorization for a service which may or may not be covered by the plan. If the existence of coverage is ambiguous, then the provider should be able to rely upon the representation of the insurance company that it will pay for such a procedure.

This decision does not, however, guarantee that a provider will be paid for all services authorized by the insurer. For instance, if the representative was not negligent in stating that the patient was insured (e.g. the policy has been canceled the day before the call was made without the representative being notified), the provider still will be unable to recover from the insurance company. In the latter example, a representation that an insurance company will pay for a service which clearly is excluded in the policy description will not be upheld.

Nevertheless, the Lordmann decision should aid physicians in collecting fees from insurance companies which negligently misrepresent coverage or which interpret ambiguous terms in insurance plans.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

ESTABLISHING A PHYSICIAN FEE SCHEDULE

Establishing and reviewing medical fees is important in ensuring that a medical practice is viable in a competitive marketplace. There are several sources that a physician can use as a benchmark to determine if his fees are reasonable and adequate. However, there are some very important guidelines to follow in structuring a fee schedule.

A policy statement of antitrust enforcement from the Federal Trade Commission's Bureau of Competition states that except in extraordinary circumstances, the Commission will not challenge participation by competing providers in surveys of prices for health care services or salaries, wages, or benefits of personnel, under certain conditions designed to ensure the data is not used to coordinate prices or costs.

To satisfy these conditions, the survey must be managed by a legitimate and independent third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association); the information provided must be more than three months old; and at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

Therefore, a physician may use survey information in determining his/her fee schedule. However, a physician should not survey other physicians for fee information. An exception to this is when there are several physicians that belong to the same group, in this instance the members of the group would be able to discuss fees among themselves but not with outside entities.

Below are several reference sources that may be used:

- Physician's Fee Guide or Annual Physicians Fee Reference (available at most medical school libraries or it can be ordered by calling 1-800-669-3337).
- Health Care Financing Administration's Resourced Based Relative Value Scale.
- Ingenix's, 2008 Relative Values for Physicians.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: September 2007

ETHICS OF CAPITATION

In recent years, the American Medical Association (AMA) and Florida Medical Association (FMA) House of Delegates have wrestled with the issue of whether capitation and other programs designed to minimize the quantity, if not quality, of health care are ethical. More importantly, however, both organizations also have addressed the issue of whether physicians who participate in such plans are acting ethically.

Critics of physician capitation argue that any system which encourages a physician to withhold care must be unethical. For various reasons, however, both the AMA and FMA have not found such plans, and those who contract with them, to be unethical per se. Two key factors have contributed to the decision not to condemn such plans and these providers. The first is the purely legal risk of an antitrust violation. Were organized medicine to make an official pronouncement finding those who participated in capitation plans to be acting unethically, such plans may have reason to allege that organized medicine (i.e., a nonintegrated collection of physicians) is attempting to organize a boycott against these plans. The result could be an expensive lawsuit which organized medicine would be forced to defend. The second reason is that participation in such a plan does not necessarily force a physician to act unethically. Admittedly, capitation plans which punish a physician financially for referring patients to specialists do provide a financial incentive to withhold care, but the AMA and FMA Councils on Ethical and Judicial Affairs both have stated unequivocally that the physician has a duty to place the well being of the patient before his or her own fiscal concerns. Therefore, a physician may act ethically in such plans if they do not succumb to the temptation of withholding appropriate care.

Constructed appropriately, capitation can encourage increased awareness of the broader physician obligation to public health as well as increased attention to efficiency in clinical practice, both of which benefit the health care system and ultimately patients. In an effort to minimize any conflict and to ensure that capitation is applied in a manner consistent with the interests of patients, the AMA and the FMA Councils on Ethical and Judicial Affairs recommend that physicians participating in such plans should adhere to the guidelines set forth below. The Councils acknowledge that, applied inappropriately, capitation can create untenable and potentially harmful conflicts for physicians and patients. Encouraging physicians to consider their obligations to patient populations and to the preservation of health care resources is appropriate only to the extent that the primacy of patient care is not threatened. Plans that are not actuarially sound require physicians to bear excessive financial risk and may place physicians in a position where they are forced to choose between individual patients needs and the needs of other plan patients. The result of this tension may be forms of circumstantial or “bedside” rationing, a sense of competition between patients for plan resources, and a significant deterioration in both the individual and public trust in physicians.

To avoid these potential conflicts, the Councils conclude that capitated plans should be constructed carefully to reflect the medical needs of plan patients. In determining capitation rates, plans should rely upon estimates of the cost associated with providing necessary care to individual subscribers rather than upon factors such as market forces or the threat of liability. Furthermore, the financial risk assumed by physicians should be limited by capitating large numbers of physicians and patients rather than individual clinicians or small, isolated groups. This will allow more accurate predictions of plan expenses in addition to reducing the impact any single clinical decision can have on the capitated pool of resources available for care, thus preserving

physicians' objectivity and autonomy. The Councils place a portion of the burden for ensuring that plans are designed appropriately on physicians by requiring them to review plans prior to signing contractual agreements to provide care.

Physicians must also be prepared to discuss with patients the financial arrangements under which they work and to appeal to the plan for changes in the amount or structure of capitated payments should design flaws become apparent. Physicians should attempt to promote full disclosure of the limitations of the managed care plan. Many of the other duties, however, fall upon the managed care organizations themselves. Among these duties are the creation of structures allowing physicians to have significant input into the plan's quality assurance, the development of adequate due process appellate mechanisms, and full disclosure to enrollees of the plan's incentives for physicians not to refer to specialists. Those readers familiar with the FMA legislative agenda may recognize these latter duties. Each of them is included and addressed in the FMA's Patient Protection Act, which continues to be a legislative priority of the FMA.

The ethics of capitation, therefore, is an issue that not only affects physicians, but managed care organizations as well. While the existence of these plans may facilitate unethical conduct, neither the plan nor its participating providers are inherently unethical. The physician nevertheless has a primary duty to act in the best interests of the patient, even if financial incentives exist to behave otherwise. The managed care organization, however, also has the same obligations to ensure the patient is aware of the plan's contents and receives the requisite level of care, regardless of the cost.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: October 2005*

EXPERT WITNESS FEES

State law is ambiguous as to how much physicians may charge to testify as expert witnesses. According to state law, as an expert witness in a civil action, a physician may be allowed an expert witness fee "in an amount agreed to by the parties." Section 92.231(2), Florida Statutes. The fee for ordinary witnesses is only $5 per day, plus six cents per mile for the actual distance covered to and from the court. Section 92.142(1), Florida Statutes. Of course, most courts hold that a physician testifying as an expert is entitled to much greater compensation, and the physician may request any "reasonable" amount. Judges routinely award $250-300/hour to family and primary care physicians and greater amounts to those with more specialized expertise.

In Workers' Compensation cases, however, deposition fees are limited to $200/hour for treating physicians and $200/day for physicians that do not provide direct professional services but merely review medical records and provide an expert opinion. Section 440.13(10), Florida Statutes. Regardless, the physician's charge should be confirmed in writing by the person employing the physician. If a physician is to render expert testimony on behalf of a defendant or the defendant's attorney, he or she should obtain, in advance, a written confirmation of the fee. The physician expert witness should also consider requiring that a portion of the fee be prepaid. Furthermore, such a fee should not be based on the outcome of the case for according to the AMA, "it is unethical for a physician to accept compensation which is contingent upon the outcome of litigation." *Opinion 9.07, AMA Council on Ethical and Judicial Affairs*.

A physician expert witness should be prepared at trial or during deposition to estimate the amount of time they spend testifying in such cases as well as their remuneration for such services. Moreover a physician expert witness should note that attorneys and other legal representatives are allowed to be present during an independent medical examination in a Workers' Compensation case.

Prepayment of Deposition Fees

As mentioned above, physicians may attempt to receive payment of deposition fees from plaintiff attorneys. While this practice is legal, it must be noted that a physician may not require the prepayment of such fees in advance if the physician has received a valid subpoena. Having received a valid subpoena, a physician must participate in a deposition regardless of whether the physician has received a prepayment of deposition fees. Failure to do so could result in a contempt citation against the physician.

Should the attorney not pay the fees after a reasonable length of time subsequent to the deposition, the physician may then petition the court, which can order the attorney to pay the fees at the risk of a contempt citation against the attorney.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

FAMILY AND MEDICAL LEAVE ACT OF 1993

The "Family and Medical Leave Act of 1993", 29 U.S.C. §§2601 - 2654. (FMLA) requires that covered employers provide up to 12 weeks of unpaid, job protected leave to eligible employees for certain family and medical reasons during any 12-month period. 29 U.S.C. §2612(a)(1).

One of the most common misperceptions regarding the law is that it applies to all employers and employees, regardless of the size of the business. In actuality, the law only applies to those employers with 50 or more employees for at least 20 workweeks in the current or preceding calendar year within a 75 mile radius and only to those employees who have worked for the employer for over one year, during which they have worked at least 1,250 hours. 29 U.S.C. §2611.

Assuming, however, that the employer and employee are covered by the FMLA, the employee still must comply with several requirements before he is eligible to take the leave. First, employees must give at least 30 days notice of their leave when such leave is foreseeable. If the need to take leave requires less than 30-days' notice, the employee must give notice "as is practicable." This generally means at least one or two business days of learning the leave is necessary. 29 U.S.C. §2612(e)(1). The FMLA provides that the employer may require medical certification to support the request for leave. 29 U.S.C. §2613. Moreover, the request for leave must be for valid reasons, such as the care of an employee's child after birth, or placement for adoption or foster care, care for the employee's spouse, child, or parent who has a serious health condition, or for a serious health condition that makes the employee unable to perform his/her duties. 29 U.S.C. §2612(a)(1).

Finally, even if an employee is covered and takes the applicable leave, the employee is not guaranteed his exact position upon returning to work. In fact, the law only requires that the employee be restored to an equivalent position with equivalent benefits and pay when they return from FMLA leave, and that the employee's benefits, such as health insurance, are continued during the leave. 29 U.S.C. §2614(a)(1), (2).

Regardless of whether an employer is covered by the FMLA, the employer should establish a consistent policy concerning how requests for leave will be handled. Not only will such a policy reduce the risk of employee complaints, but it will also eliminate much of the emotional strain associated with making case by case determinations.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: September 2007

FLORIDA PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

The Bill of Rights applies to all physicians who see patients in an office setting and to hospitals and ambulatory surgical centers that offer emergency, outpatient, or inpatient services.

Section 381.026, Florida Statutes, requires that physicians and health care facilities, if requested, shall inform patients of the address and telephone number of each state agency responsible for responding to patient complaints. Physicians and health care facilities are also required to adopt and make public, in writing, a summary of the rights and responsibilities of patients. This is best accomplished by posting a copy in the office in a conspicuous place. Fines for noncompliance range from $100 for nonwillful violations to $500 for willful violations. Rule 64B8-8.001(2)(mm), Florida Administrative Code.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Florida law requires that health care providers or health care facilities recognize patient rights while they are receiving medical care and that patients respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. Patients may request a copy of the full text of this law from their health care provider/facility. A summary of the Patient's Bill of Rights and Responsibilities follows:

- A patient has a right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has a right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

GIFTS TO PHYSICIANS FROM THE PHARMACEUTICAL INDUSTRY

It is common practice for pharmaceutical companies to provide gifts to physicians as a way of advertisement, financial support and to uphold the customary practices of the industry. Some states have partial or complete bans on receiving gifts from the industry, fearing prescribing persuasion and other adverse effects. While Florida has no legislation on accepting gifts from the industry, the American Medical Association (AMA) provides guidelines to help protect physicians, to minimize conflicts of interest and to avoid public scrutiny. The following is a summation of the AMA's policy on physicians accepting gifts from the industry.

A good general guideline is to only accept gifts that somehow provide a benefit to patients and/or serve a genuine educational function. The gift should not be of substantial value and should be related (even minimally) to the physician's area of practice. Subsidies for hospitality, meaning travel, lodging or other personal expenses, should not be permitted outside of modest meals or other events held as part of a conference or meeting. However, subsidies to defray the costs of continuing medical education or other professional meetings contribute to patient care and are therefore permissible. No gifts should be accepted on a conditional basis as this causes a direct conflict of interest, especially if the gift relates to a physician's prescribing practices. *Opinion 8.061, AMA Council on Ethical and Judicial Affairs.*

Medical students are subject to the policies of their academic institution. For example, the University of Florida, College of Medicine has a Conflict of Interest Program that generally prohibits any gifts, subsidies, or other benefits from the industry to College of Medicine students or personnel.

Until Florida passes legislation limiting the acceptance of gifts from the industry, physicians should keep in mind the above-mentioned guidelines as they exercise their discretion.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: March 2013*

HMO REIMBURSEMENT FOR EMERGENCY CARE AND SERVICES

Health maintenance organizations are governed under Chapter 641 of the Florida Statutes. Section 641.47(8), Florida Statutes, defines "emergency services and care" to mean "medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital."

Subsection 641.513(3)(a), Florida Statutes, states, "The health maintenance organization shall compensate the provider for the screening, evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The [HMO] shall compensate the provider for emergency services and care. If a determination is made that an emergency condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered."

Subsection 641.513(5), Florida Statutes, states that when emergency services and care are rendered to a patient by a non-contracted physician, the HMO must reimburse the physician the <u>lesser</u> of:

(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided; or
(c) The charge mutually agreed to by the HMO and the provider within 60 days of the submittal of the claim.

The reimbursement must be net of any applicable copayment authorized.

Note, however, if the person is enrolled in a Medicaid HMO, the HMO is allowed to reimburse the lesser of the above three choices <u>or</u> the Medicaid rate.

Furthermore, an HMO is not allowed to conduct a post-care analysis and make its own determination as to whether such a condition was present. Once the attending physician indicates in the chart that such a condition exists, the HMO is required to pay for medical care and services rendered in treating the condition.

If you are having difficulty in obtaining proper reimbursement for services rendered to an HMO patient, it is important to note that you cannot balance bill the patient. Your sole recourse for reimbursement lies with the patient's HMO. In situations where the HMO and the physician cannot agree on the proper reimbursement rate, physicians may obtain assistance in getting their claims paid by using the Statewide Provider and Health Plan Claim Dispute Resolution Program [Section 408.7057, Florida Statutes]. Application forms and instructions on how to file claims are available from Maximus, an independent dispute resolution organization contracted with AHCA, by calling 1-866-763-6395 and asking for the "Florida Appeals Process." You may also call AHCA's Bureau of Managed Care at (850) 487-0640. There is a charge for reviewing claims. The charge is to be paid by the non-prevailing party.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last update: June 2010

HURRICANE PREPAREDNESS

General

Hurricane preparedness must be an essential part of daily life for Floridians; it is crucial not to underestimate the power of these storms. Every year Florida sits directly in the path of a hurricane and as a result, physicians must be prepared to effectively manage their offices. Physicians can mitigate damages caused by natural disasters by having effective preparedness plans that encompass both what to do before and after a hurricane. While hurricanes are almost certainly the most prevalent threat to the State of Florida, stay conscientious of other disasters such as tornadoes, floods, fire, and bomb threats.

Insurance

Probably one of the most important considerations in a physician's hurricane preparedness plan is to have a comprehensive knowledge on what your insurance policy covers and in what areas the policy might be lacking. Consider whether you need flood insurance, insurance to cover payrolls or other business expenses in the event there is damage to the medical office. If one does not already exist, create an inventory of office equipment or check with your insurance provider on how to document your assets.

Keep copies of your insurance policies and contact numbers in a safe location, preferably off-site or in a fireproof document box in case of an emergency.

Preserving Patient Medical Records

Another major concern for medical offices is how to preserve medical records when threatened by a natural disaster. After Hurricane Katrina destroyed hundreds of thousands of documents, the value of electronic medical records was realized. The loss of medical records is detrimental to both the physician and the patient, and physicians should take the necessary steps to prevent the loss of such records. Keep in mind the four phases of emergency management: mitigate, preparedness, response, and recovery.

Mitigate future damages by analyzing your record keeping system now. If the practice utilizes an electronic system for medical or billing purposes, then prepare for a hurricane by developing a policy on the best way to back up the data. If the practice uses a paper system, the physician may want to consider investing in fireproof cabinets or an electronic database, storing copies off-site, or developing some other policy that will help protect medical records.

Have a meeting with main employees in order to develop a response system for an imminent hurricane. This will help to alleviate any panic or chaos if physicians and employees know their role in protecting the practice.

Recovery may be as simple as removing shutters or as severe as having to relocate. Create a recovery plan that encompasses both ends of the spectrum. The recovery plan should anticipate partial or full loss of medical records. This policy would include a plan on how to contact affected patients; if the contact list is destroyed, consider an ad in the local newspaper. Also determine how to reestablish crucial information such as patient medication lists.

Other Considerations

Perhaps a worst case scenario is the medical office is damaged to such an extent that relocation has become the only option. If this is the best option for the practice, please refer to the article titled RETIRING/CLOSING/RELOCATING A PRACTICE within this handbook.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: March 2013*

IMPAIRED PRACTITIONERS

Not many people are aware of it but the Florida Medical Association helps staff one of the most important programs in the State of Florida. It is the Professionals Resource Network, Inc., based in Fernandina Beach, Florida.

PRN has a contract with the State of Florida to provide services to all impaired health care practitioners in the State, except nurses, who have a separate program based in Jacksonville Beach (the Intervention Program for Nurses). PRN also provides services to veterinarians, accountants, and harbor pilots. PRN is headed by Dr. Raymond Pomm, a psychiatrist and addictionologist with many years experience working with impaired health care professionals. PRN customarily carries a caseload of 1,200 active contracts.

PRN does not provide treatment to impaired professionals, but acts as a clearinghouse and monitoring station. PRN reviews evaluators, treatment providers, monitors and support groups and approves those that meet the standards of the program and the Department of Health. These entities are then allowed to provide services to impaired practitioners within the PRN program. If a health care professional contacts PRN and reports their impairment two things occur: (1) by law, the professional cannot be prosecuted for the impairment as long as he or she follows PRN's recommendations and (2) PRN will get them the help they need.

This usually begins with an evaluation by a qualified professional. If the evaluator recommends treatment, the health care professional will enter either inpatient or outpatient treatment for their addiction. Recovery also may include attendance at support groups, drug screenings, family counseling and regular contact with PRN staff. PRN closely monitors all aspects of the professional's recovery and as long as the health care professional stays in compliance with the PRN program, the regulatory agencies do not become involved.

PRN also works closely with the Boards of Medicine, Osteopathic Medicine, Dentistry, and other health boards, to monitor those professionals whose impairment has led to formal discipline. These health care professionals are in PRN under order of their Board and can be immediately suspended from practice if they do not comply with the orders of their Board. The orders may include withdrawal from practice, treatment, drug screenings, etc.

PRN monitors physicians with numerous types of impairments including alcoholism, drug addiction, mental illness, physical impairments including HIV/AIDS and problems with disruptive behavior. Many entities refer professionals to PRN, including hospitals and clinics, other providers, patients, co-workers and friends. The program has been in existence since the 1980's and is recognized nationwide as one of the best programs in the country. The Florida Medical Association is proud to be a part of this fine tradition of protecting the public and assisting those health care professionals in need.

The Professionals Resource Network can be contacted at 1-800-888-8776

The Intervention Program for Nurses can be contacted at 1-904-270-1620

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

INTRACTABLE PAIN STATUTE

The Florida Medical Association has historically supported legislation that would allow physicians to prescribe and administer controlled substances to those suffering from intractable pain, even if the cause of the pain cannot be removed or otherwise treated.

In 1994, the FMA successfully lobbied the Legislature to pass Section 458.326, Florida Statutes. This statute allows a physician who diagnoses a patient as having intractable pain to prescribe or administer any controlled substance under Schedules II through V for the treatment of such pain, provided that the physician acts in a "reasonably prudent" manner. While the statute does not condone or authorize euthanasia or physician assisted suicide, it does protect the physician who wishes to minimize the pain of a patient whose pain may not be treatable in any other manner.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

LIMITED ENGLISH PROFICIENT (LEP) PATIENTS

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color and national origin by organizations receiving federal funding.

According to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), discrimination based on national origin includes policies or procedures that may have a disparate impact on non-English speaking persons. A Limited English Proficient (LEP) individual is “unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language.” Title VI therefore requires all recipients of federal financial assistance from HHS to take reasonable steps to ensure meaningful access for LEP individuals.

Who is covered?

Covered entities may include:

- Hospitals and nursing homes
- Managed care organizations
- Head Start programs
- State, county and local health and welfare agencies
- Universities and other entities with health or social service research programs
- State Medicaid agencies
- Physicians and other providers who receive Federal financial assistance from HHS

<u>Note:</u> Providers who only receive Medicare Part B payments are **not** considered recipients of HHS assistance.

Small practitioners and providers that accept Federal financial assistance will not be held to fulfill the same level of language services as practitioners and providers with larger budgets. While OCR will determine compliance on a case by case basis, OCR will use the following four-factor analysis to balance the interests of smaller providers with the needs of LEP patients: “(1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program, activity or service provided by the recipient; (2) the frequency with which LEP individuals come in contact with the recipient's program, activity or service; (3) the nature and importance of the recipient's program, activity, or service; and (4) the resources available to the recipient and costs.”

Types of language assistance services

Regardless of whether a certain provider or practitioner is a covered entity, the Florida Department of Health (DOH) warns against using bi-lingual employees, family members, friends, minors, volunteers, or other patients as interpreters and/or translators. This poses a danger for increased liability, substantial privacy violations and critical misinterpretations. The DOH lists appropriate interpreters as trained bilingual staff, on-staff interpreters, contract interpreters, and telephone interpreters. Additionally, vital documents should be translated by a professional translator.

For More Information

For more information and FAQ's, please see the "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" at:

http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

---

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

MANAGED CARE CONTRACTS

THINGS TO CONSIDER

A bad contract with a Managed Care Organization (MCO) can be a nightmare for your practice, the patients you treat, and can play havoc with your finances. Some physicians find themselves seeing too many patients in order to maintain cash flow as a result of poor reimbursements from MCOs. You can avoid this catastrophe by spending a little time reading and understanding MCO contracts BEFORE you sign them. This article will cover things to consider before you review any contracts, including language that you should consider in any contract and provisions to question and avoid. This article will not cover reimbursement issues except as required to ensure the contract does not violate Florida law.

Before you start to review MCO contracts, you should analyze your office performance and look at your internal contracting procedures. While the size of the practice will dictate your policies, every office should periodically review their procedures. Do you know what your time is worth? Do you know the extent of your overhead costs? According to Dr. Tom Hicks (a family practitioner and the Medical Director of Patients First, Tallahassee) an excellent, simple calculation is to take your overhead costs and divide by the number of patients seen (or number of procedures accomplished). This gives you a known amount (sans professional costs) to use in evaluating contract reimbursement rates. What percent of your practice does patients from each MCO represent? If 20% of your practice is with a particular HMO, what will you do when the HMO cuts your fees? With a large number of patients from one MCO, you reduce your ability to cancel or renegotiate a contract. Who reviews and understands MCO contracts in your office? Who monitors not only your compliance with the contract but the carriers' compliance as well? These are a few of the questions you should ask before you review MCO contracts.

Through the Office of Insurance Regulation (OIR), the state has many laws to regulate the insurance industry. For example, Chapter 641, Florida Statutes, regulates Health Maintenance Organizations (HMOs) and Chapter 627, Florida Statutes, regulates the other insurance entities. Included in the insurance code are many protections for Florida patients. Statutes outline items that must be included in subscriber contracts, the clarity of the language, rates, etc. MCOs are required to have OIR pre-approval of any subscriber contract prior to offering the plan for sale. For physicians there is NO SIMILAR protection. The state considers you to have enough knowledge of contract law to protect yourself.

During your initial scan of the contract, identify sections and elements that should be in a balanced and fair contract. Often the MCO will include clauses for its own protection and self-interest that should be avoided by the provider. In your review, mark these provisions for question and/or negotiation.

CONSIDER/INCLUDE:

(1) FINANCIAL IMPLICATIONS. While your primary purpose may be to provide services to patients; if you do not cover your costs you will not be in business for very long.

The contract must clearly define compensation rates/amounts. MCO contracts usually specify a fee schedule; make sure you review, understand and accept any referenced schedule. Also ensure that a copy is included as an attachment to the contract. If different fee schedules are incorporated into the contract, make sure you have copies of each and understand their financial implications. If appropriate, address the definition of "usual and customary" (and when it might apply, i.e. for emergency services). Often MCOs will provide you with a small sample of what they consider to be usual and customary reimbursement fees. Make sure you review enough examples to feel comfortable with their payment plan. Discuss exactly when and how authorizations are obtained – does authorization guarantee payment? Put any agreed upon

modifications to their normal procedures into your contract. If the MCO ties the fee schedule to Medicare RBRVS, you might want to designate a specific year, or specify an exact conversion factor that can only be changed by mutual agreement. Also have some understanding of compensation rates should you decide not to sign the contract and treat a MCO patient as a non-participating provider.

You should have some understanding of the MCO's policyholders'/subscribers' agreements as well. Subscriber contracts define the covered services for which you will be reimbursed (and either by omission or exclusion, the non-covered services for which you may bill the patient your usual and customary amounts). Employees of the MCO will often erroneously give you authorization to perform a non-covered service; however, at a later date the MCO will deny payment for that service.

You must understand the administrative burden the contract will require, for example, your office costs to comply with the contract (i.e. claim filing and follow-up costs). Ask if the MCO charges administrative fees (by withholding a percentage of monthly or annual reimbursements). Are fees built in, if so, are they excessive? This cost can mean the difference in profit or loss from MCO contracts for small practices. Dr. Hicks stated that one contract he reviewed entitled the MCO to compensation of excess costs incurred if a physician referred a patient to a non-participating provider.

Watch out for language that says "will pay the lesser amount of …" This is a red flag for an issue that requires additional investigation. How to negotiate with the MCO and make changes to a proposed contract will be discussed later in this article.

(2) PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS. Because of the environment of professional liability insurance in Florida, many physicians are self-insuring or going "bare." This is not a reference about heading to the nearest nude beach, but to the minimum coverage allowed under the Florida Financial Responsibility law [Section 458.320, Florida Statutes] for physicians holding an active license. When a MCO discovers you are self-insuring, it will reevaluate your credentialing and assess your risk to the company - many physicians who self-insure are receiving contract termination letters. MCO contracts often require medical malpractice insurance in specific amounts, for example, coverage of $1,000,000 per occurrence and $3,000,000 aggregate. To avoid problems, we suggest that you have the language changed to say that the MCO "accepts $250,000/$750,000 or the lesser amount required by state law;" or simply have the contract require you "be in compliance with the state financial responsibility laws." Remember amounts may vary depending on if you have or need hospital privileges. Note that the contract may require that you have privileges in at least one member hospital.

(3) NOTICE REQUIREMENTS. Make sure the MCO cannot unilaterally change/amend the contract or their rules/policies without notice to you. Ensure you get sufficient notice and have the ability to change/amend/reject any proposed changes (i.e. all changes require the agreement of both parties) or you have the ability to terminate the contract on the effective date of the contested change. You should be given at least 60 days to review any proposed changes. This notice will prevent a decrease in your reimbursement fees without your knowledge. Some contracts provide for notice of amendments and effective dates to be given by the MCO, but provide no options for your approval, ability to recommend changes, etc. Some contracts are very detailed, including how the notices are to be delivered. Make sure you understand and agree with these provisions. The time to protect yourself and your practice is BEFORE you sign the contract. Note that notice requirements will vary in different portions of the contract – read the entire contract.

(4) TERMINATION/RENEWAL LANGUAGE. The contract usually identifies a list of circumstances under which termination "for cause" may occur. It should also allow either party to terminate the contract without cause, with 60 or 90 days notice. Watch for language limiting

termination effective dates. For example, don't get trapped into the situation where you can only get out of the contract on the anniversary date. Watch out for automatic or immediate termination language, for example: "if disciplined by a regulatory agency," - could this include a very minor offense? Make sure sufficient time is established for contract review before your anniversary or renewal date.

WATCH OUT FOR:

(1) HOLD-HARMLESS CLAUSES. These clauses declare that the provider shall indemnify and hold the MCO and third parties harmless from any liabilities incurred as a result of professional services provided (or not provided) by the physician with respect to a covered subscriber. Many MCO contracts presented will contain this clause. WE SUGGEST YOU CROSS OUT AND INITIAL/DATE THIS CLAUSE. As a minimum you should negotiate a mutual hold-harmless clause.

NOTE:

Minor contract changes can be made in pen and ink on the face of the contract by simply initialing and dating the change. Major changes or new language should be by AMENDMENT/ATTACHMENT/ADDENDUM to the contract and signed by both parties.

(2) MOST FAVORED NATION CLAUSE (OR MOST FAVORABLE AGREEMENT CLAUSE). This clause requires the provider to charge the MCO the same discounted rate (i.e. the lowest contracted rate) negotiated with any other MCO. Thus, if you give one MCO a 20% annual discount you must give the MCOs the same discount). WE SUGGEST YOU CROSS IT OUT AND INITIAL/DATE.

(3) ALL PRODUCTS CLAUSE. This clause makes you a network member for all plans and products the MCO writes (HMO, PPO, Point of service, etc., which creates reimbursement issues and termination problems). WE SUGGEST YOU CROSS IT OUT AND INITIAL/DATE. The best method is to have separate contracts for each plan you are going to participate in or have the contract identify only those plans you wish to participate in. Certain provisions are contrary to Florida law.

(4) RECORDS ACCESS AND CONFIDENTIALITY CLAUSES - Be cautious of how much information you must provide the MCO about your practice and your patients (including MCO access to your records and consent and cost requirements for obtaining or auditing copies of patient records). Some contract language requires you to indemnify the MCO for any fines or penalties they get based on inaccurate or incomplete information they obtain from you and pass on to others. Some contracts give the MCO access to your records up to five years after your contract terminates. Often contracts say they can access your records "upon reasonable notice." We suggest you define what reasonable is. It is crucial for you to understand what you are signing.

(5) NON-COMPETITION CLAUSES and EXCLUSIVE CONTRACTS. Contract language may preclude you from participating in other plans. These clauses are very dependent on the location and environment of your practice, but they only protect the MCO and never serve the physician well. Several types are in violation of Florida law.

(6) WHISTLE-BLOWER CLAUSES. These clauses require that you report other providers for inappropriate use of discount rates, non-participating providers rendering care and balance billing, etc. Because of recent cases, these clauses don't appear often.

OTHER CONSIDERATIONS:

(1) MAKE SURE THE CONTRACT DOESN'T VIOLATE FLORIDA LAW. Section 641.315, Florida Statutes, addresses and defines many terms and conditions required in an HMO provider contract. Especially ensure the contract aligns with the prompt pay laws (see Sections 641.3155 and/or 627.6131 Florida Statutes), which includes timelines for claims, denials, payments, appeals, interest, etc. MCO contracts will often include balanced billing language so make sure it is in accordance with Florida law. Balanced billing is usually not allowed within HMO contracts; however, it is allowed for non-participating providers seeing PPO patients. Also for PPOs, copay and deductible language will usually be included. If the contract mentions a section of Florida Statutes, read it, and make sure it identifies the year since statutes have the potential to change annually.

(2) WATCH FOR UTILIZATION REVIEW LANGUAGE. Some contracts will require providers to "fully comply with" the MCO's utilization management program. Make sure you understand what that program is and if it will affect your reimbursement rates. The Florida legislature is establishing more requirements for MCOs to audit/police medical providers. It is also giving administrative agencies more authority to review and prosecute "utilization" violators (which are reported by the MCOs). Ensure adequate and agreeable appeal language is included. The legislature is also demanding increased use of practice parameters and guidelines by physicians; violations open new doors for medical liability suits.

(3) MAKE SURE YOU UNDERSTAND THE MCO DISPUTE RESOLUTION PROCESS. As always, make sure you have adequate notice and have time to respond or provide required information. Is there an arbitration clause; is it final and binding? Where would arbitration be held (we suggest you make it in your county)? If you want the ability to arbitrate, make sure you understand all potential issues involving arbitration and ensure that parties share costs.

(4) WATCH FOR REFERENCED BUT MISSING DOCUMENTS. MCO contracts will often reference other documents (i.e. an unfamiliar fee schedule, definitions, programs, etc.) that are incorporated into the contract, but not provided to the physician. Watch for "except as otherwise specified herein" language, or "as required by applicable law." If you can't find what they are referring to, ask to see/review copies or have the MCO point it out BEFORE you sign the contract.

(5) DON'T LEAVE ANY BLANK OR OPEN SPACES. This will only lead to misunderstandings and disputes. As a minimum initial the space so you will remember that it was blank.

(6) MAKE SURE YOU UNDERSTAND THE MCO's REFERRAL POLICIES. Does the contract allow you to refer patients to specialists as you deem medically necessary?

YOU CAN NEGOTIATE WITH MANAGED CARE ORGANIZATIONS

Contracts are written by and for the benefit of the MCO, thus it becomes your responsibility to make the relationship work for you. While the ability to negotiate often depends on the number of providers in your locality – groups reduce the number of individual providers available and give bargaining power – you will never know your power to negotiate until you exercise it. Always think about and prepare offers and counter offers. Knowledge is power - contract negotiating power and the power to save/make money with MCO contracts. Be reasonable, go into the negotiation with a "win-win" philosophy, and use the negotiation exercise to open an honest dialog with the MCO. But also remember, "If it ain't in writing, it ain't agreed on." Also do not get frustrated talking to MCO provider relations personnel. If they do not have the power to modify your contract, ask and get to the correct authority immediately.

You can change the contract mailed to you. Look for potential additions or changes in contract language in sections dealing with the following: claims filing/payment deadlines if different from state law; how the MCO resolves disputes; amounts paid for primary, secondary, and tertiary procedures; the ability to drop patients/subscribers; contract termination policies; charging subscribers/members for non-covered services; refunds; contract revisions; carve-outs, etc. Always be alert for phrases that limit the liability of the MCO. An area that providers often overlook when reviewing an MCO contract is the MCO's CPT code bundling and modifier methodology. MCOs have proprietary software programmed to accept only certain ways of bundling CPT codes and deny the claim if certain modifiers are used. There will be some variation between MCOs in their coding and bundling methodology and understanding each will reduce billing frustrations. One approach is to offer several combinations of oft-performed procedures (using CPT codes) that you use in your practice to the MCO and see how they would be reimbursed. If you disagree with the MCO's approach, clarify any agreement you make in the contract. Understand the MCO's bundling methodology BEFORE you sign the contract.

Be aware that there are probably certain contract clauses the MCO will not negotiate (different clauses for each MCO) and you must decide if you will compromise or if they will be deal breakers.

FINAL THOUGHTS:

If you don't have the time to review your contracts, for the next two or three years, pay an attorney to review them for you; have him/her sit down with you and explain the contract clauses and pitfalls. After three years you should (1) be educated and feel comfortable enough to do the review yourself, and (2) be able to figure out the financial viability of each contract. It is easy to go from the foreign to the familiar - with practice comes increased speed of the review and increased economic benefit.

Don't sign a contract unless you have read and understand all the provisions and conditions. Don't sign every MCO contract you are offered. Review them and make intelligent, financially responsible decisions. Consider dropping the lowest money maker (or loser) each year. Many MCO's will not negotiate a contract until a provider threatens to not renew.

While a recent federal court case, International Healthcare Management et al. vs. The Hawaii Coalition, the Hawaii Medical Association, et al., held that medical associations can review and comment on physicians' managed care contracts without fear of violating federal antitrust laws that prohibit independent physicians from banding together to negotiate contracts, the FMA is just not staffed to provide this service. The FMA, however, does have a Lawyer Referral Service that it operates to help physicians find competent legal representation. The Lawyer Referral Service can be accessed online at www.flmedical.org/lawyer.aspx. If you need more individualized assistance, please contact the FMA legal department at legal@flmedical.org.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.
Last Update: October 2005

MEDICAL ASSISTANTS

Section 458.3485, Florida Statutes, defines the term "medical assistant" as a "professional, multi-skilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician. This practitioner assists with patient care management, executes administrative and clinical procedures, and often performs related managerial supervisory functions." Competence in the field requires that a medical assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics. The statute provides that a medical assistant may undertake the following duties under the direct supervision or responsibility of a licensed physician:

A. Performing clinical procedures, to include:

   1) performing aseptic procedures

   2) taking vital signs

   3) preparing patients for the physician's care

   4) performing venipunctures and nonintravenous injections

   5) observing and reporting patient's signs or symptoms.

B. Administering basic first aid.

C. Assisting with patient examinations or treatments.

D. Operating office medical equipment.

E. Collecting routine laboratory specimens as directed by the physician.

F. Administering medication as directed by the physician.

G. Performing basic laboratory procedures.

H. Performing office procedures including all general administrative duties required by the physician.

I. Performing dialysis procedures, including home dialysis.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

MEDICAL CARE FOR MINORS

Traditionally, and by statute, parents are the natural guardians of their minor children. A minor is defined as a person who has not reached the age of eighteen and whose disabilities have not been removed by marriage or otherwise. Section 744.102(13), Florida Statutes. It is generally presumed that when children lack the capacity to make certain decisions, their parents, as their natural guardians, make those decisions for them. In general, parental consent is needed before a physician may examine or treat a minor. However, not all decisions are removed from the minor. The state of Florida has recognized this through the passage of several statutes that remove the disability of non-age under certain circumstances.

For example, an unwed pregnant minor may consent to medical treatment relating to her pregnancy without the consent of her parents, and the medical records of such treatment are to be treated as the records of an adult. Section 743.065(1), Florida Statutes. An unwed minor mother may also consent to medical or surgical care or services for her child without the consent of her parents, and the medical records of such treatment are to be treated as the records of an adult. Section 743.065(2), Florida Statutes. Similar issues also arise in the case of sexually active minors who are at risk of becoming infected with sexually transmitted diseases.

It is for this reason that the Florida Legislature enacted Section 384.30, Florida Statutes. This statute is meant to encourage minors to seek treatment for such conditions without the need for parental consent or the fear that the records of their treatment could be released to their parents. According to this statute, a physician "may examine and provide treatment for sexually transmissible diseases to any minor... [and the] consent of the parents or guardians of a minor is not a prerequisite for an examination or treatment. [Furthermore] the fact of consultation, examination, and treatment of a minor for a sexually transmissible disease is confidential and exempt from the provisions of s. 119.07(1) and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as provided in s. 384.29 [i.e. unless consented to by a minor]."

As a result of Section 384.30, Florida Statutes, physicians do not need to obtain the consent of parents or guardians before examining and treating a minor for a sexually transmissible disease. The physician must also be aware that bills for such services may not be sent to the parents, as this practice would constitute a violation of the minor's right to confidentiality.

In addition to the above, Section 381.0051(4), Florida Statutes, provides that a physician may provide maternal health and contraceptive information and services of a <u>nonsurgical</u> nature (nonpermanent internal contraceptive devices are considered nonsurgical) to any minor, who:

- Is married;
- Is a parent;
- Is pregnant;
- Has the consent of a parent or legal guardian; or
- May, in the opinion of the physician, suffer probable health hazards if such services are not provided.

Section 743.064, Florida Statutes, allows a physician to provide emergency medical care or treatment to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical well-being of the minor, and provided such emergency medical care or treatment is administered in a

hospital licensed by the state under Chapter 395 or in a college health service. This care can only be rendered if the minor is unable to reveal the identities of his parents or guardians and their identities are unknown, or if his parents, guardian or legal custodian cannot be immediately located by telephone.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

MEDICAL CLINIC REGISTRATION

Florida law now requires that a medical clinic that is not wholly owned by a physician or a direct member of the physician's family become licensed by the State of Florida. The Agency for Health Care Administration is administering this program. It is imperative that all clinics that fall under the law become licensed, as the fines for failing to do so in a timely manner are substantial. In addition, failure to become licensed constitutes a felony; and all charges and reimbursement claims made by an unregistered clinic are noncompensable and unenforceable.

Section 400.9905(4), Florida Statutes, sets forth the exemptions, i.e., the entities that do not have to become licensed. In addition to clinics owned by physicians, the following entities are included in the list of facilities that ***do not*** have to become licensed:

- Mental health facilities licensed pursuant to Chapter 394, Florida Statutes
- Hospitals and other facilities licensed pursuant to Chapter 395, Florida Statutes
- Substance abuse facilities licensed pursuant to Chapter 397, Florida Statutes
- Nursing homes licensed pursuant to Chapter 400, Florida Statutes
- Entities that are exempt from federal taxation
- Community college or university clinics
- Clinical facilities affiliated with accredited medical schools
- Entities that are owned, directly or indirectly, entities licensed or registered by the state pursuant to Chapter 390, 394, 395, 397, 400, 463, 465, 466, 478, 480, 484 or 651.
- Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to the chapters above.
- Entities that are under common ownership, directly or indirectly, with an entity listed above.
- Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.
- Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of this part.
- Entities that employ 50 or more licensed health care practitioners licensed under Chapter 458 or 459 where the billing for medical services is under a single tax identification number.

Medical clinics that are required to be licensed under this law will be subject to inspection. They must also employ a medical director who is responsible for the clinic's activities. The medical director's duties shall include ensuring that all practitioners at the clinic are in compliance with licensure and billing laws. Any physician thinking of becoming a clinic's medical director should obtain a copy of Section 400.9935, Florida Statutes, before agreeing to do so. The statute sets forth the areas for which the medical director will be responsible. Medical directors who fail to ensure compliance in these areas can be prosecuted by their licensure board as well as in criminal court, and may also be liable in civil court for their acts.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: March 2015

MEDICAL RECORDS

Every physician is aware of the need to maintain adequate medical records for each of their patients. Such records are crucial to providing quality health care by serving as a basis for planning the patient's care and recording essential medical information concerning the patient's condition and treatment. The records can also protect the physician legally by documenting the patient's changing medical condition and evaluation, as well as actions taken by the primary care and consulting physicians. Furthermore, the need for adequate medical records is recognized not only by physicians, but is also regulated by federal and state statutes and rules regulating the content, retention, and accessibility of medical records.

Federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), to implement the Health Insurance Portability and Accountability Act of 1996 (HIPAA), those standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. HIPAA represents a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule. HHS has produced many materials discussing and explaining the provisions of the privacy standards. These materials are available at *http://www.hhs.gov/ocr/hipaa*. A detailed analysis can be found at www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html. Unless expressly stated, the provisions of Florida law discussed below are not preempted by the federal privacy standards.

According to Section 458.331(1)(m), Florida Statutes, a physician may be disciplined for "[f]ailing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered, and reports of consultations and hospitalizations." Moreover, Rule 64B8-9.003, Florida Administrative Code, in addition to the above, mandates that the records be legible and contain sufficient information to "identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately..." Finally, the physician should be aware that failure to keep written medical records could subject the physician to penalties ranging from a mere reprimand to a combination of a two-year suspension, followed by probation and a $5,000 fine. Section 456.057(15), Florida Statutes.

Having created an appropriate record, physicians frequently are unsure of the time period during which they must maintain these files. While Rule 64B8-10.002, Florida Administrative Code, mandates that a physician retain these records for at least five years, the rule also recognizes that this time frame "may well be less than the length of time necessary for protecting the physician." Under the Statute of Limitations, a claim of malpractice may be brought against a physician up to seven years after "the date the incident giving rise to the incident occurred." (If it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury, otherwise the standard of limitations is two years) Section 95.11(4)(b), Florida Statutes. For this reason, it is recommended that physicians retain medical records for at least seven years.

Admittedly, the storage of seven years' worth of medical records may be both expensive and burdensome. Therefore, some physicians have chosen to store patient records electronically for easier storage. While many courts allow reproductions of medical records to be admitted as evidence, even these courts require that several precautions be taken. First, the physician must have a written policy explaining which types of records are to be stored electronically and this policy must be applied to all records uniformly. Secondly, a custodian of the records must be appointed. Overall, extreme care must be taken prior to instituting any electronic record

reproduction/storage system. Therefore, before instituting any document storage conversion, a physician should seek the input of qualified legal counsel.

Finally, having properly created and preserved a medical record, a physician must ensure the record remains confidential. Section 456.057(7), Florida Statutes. Nevertheless, the physician must, upon request, furnish the patient or its legal representative with a copy of "all reports and records relating to [the patient's] examination or treatment... (other than AIDS, mental, and substance abuse records)," although a psychiatrist or psychologist may substitute a report of the examination in lieu of the medical record. Section 456.057(6), Florida Statutes.

If a patient requests a copy of his/her medical records, it is very important that the physician provide the patient with a complete copy of **all** the records, which would include, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient, even those records obtained from another physician. Section 456.057(6) and (14), Florida Statutes, Rule 64B8-9.003(3), Florida Administrative Code. Failure to do so may subject the physician to disciplinary action.

Moreover, a physician must release copies of the medical record to parties authorized by the patient, and the physician must release copies of the record, even if not authorized to do so by the patient, if the records have been subpoenaed for a deposition, evidentiary hearing, or trial. Section 456.057(7), Florida Statutes.

It should be pointed out, however, that HIV/AIDS records, sexually transmissible disease records, alcoholic drug abuse records, and psychiatric and psychotherapeutic records are extremely confidential medical records and are not to be disclosed pursuant to a general release. The disclosure of these types of records requires a written release by the patient identifying the specific records to be released or a court order to the same effect. Even a subpoena signed by an attorney is ineffective to release these super confidential records. In maintaining a patient's medical records, it is a good idea to clearly indicate a presence of super confidential materials to avoid inadvertent disclosure.

Physicians are required to keep a record of all disclosures of information contained in the medical records to third parties, including the purpose of the disclosure. Physicians must maintain the record of the disclosure in the patient's medical records. The party to whom the physician disclosed the information may not disclose the patient's medical information without the expressed written consent of the patient or the patient's legal representative. Section 456.057(11), Florida Statutes.

The Board of Medicine through Rule 64B8-10.003, Florida Administrative Code, governs the costs of reproducing medical records. The rule encourages physicians to provide patients with a free copy of their records, especially when the patient is economically disadvantaged. This is not a requirement, however. A physician required to provide copies of medical records to a requesting party may charge only for the "reasonable costs" of reproducing the records, which is defined as follows:

- For patients and governmental entities, a physician can charge no more than $1 per page for the first 25 pages, and 25 cents for every page thereafter.
- For other entities, the reasonable costs shall be no more than $1.00 per page.
- The reasonable costs of reproducing x-rays and other kinds of special records shall be the actual costs, which mean the cost of material supplies as well as labor and overhead costs.

While a physician can condition the release of medical records upon payment of the copying costs, the release cannot be conditioned on payment of the physician's bill for services rendered. Upon the receipt of a written request, the physician must provide the patient with a copy of his medical records within a reasonable time, regardless of whether or not he has outstanding charges due on his account.

As has been shown above, medical records certainly are subject to a variety of federal and state statutes and regulations, all of which the physician must be aware of in order to avoid potentially drastic state action. In order to minimize this risk, it is recommended that the physician's medical record procedures be reviewed for compliance with the aforementioned laws. The physician may wish to enlist the aid of a qualified health care attorney in this endeavor, as the input of informed legal advice may well aid the physician in the development of a medical record program which is workable and in compliance with state mandates.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: November 2013*

MEDICARE CONTRACTUAL OPTIONS

There are three Medicare contractual options for physicians. Physicians may sign a PAR agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. They may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims. Lastly, they may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves.

Physicians who wish to change their status from PAR to non-PAR or vice versa are required to do so before Dec. 31, 2009. Once made, the decision is binding throughout calendar year 2010 except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days' notice before the first day of the quarter the contract takes effect. Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. In addition, some states have enacted laws that prohibit physicians from balance billing their patients.

Both First Coast and the AMA have information on their websites. The AMA information is from 2008 for 2009 options. They have not put out the 2010 as yet. My guess is it will be out shortly since physicians need to make this decision between mid-November and December 31st. The information has not changed and is an excellent explanation of the participation options available. The file is attached. In addition, First Coast has information on how to "Opt out" of Medicare on their site. http://medicare.fcso.com/Opt_out/138524.asp. If they are a PAR provider, they would not need to do anything to remain as a PAR provider. If they are a PAR provider and want to change to a non-PAR provider, they would have to contact First Coast to see what they would need to fill out (see attached file from CMS on what to do.) First Coast contact information is at: http://medicare.fcso.com/Contacts/156290.asp.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: January 2010*

NONCOMPETITION CLAUSES

Often overlooked in many employment contracts by employers and employees alike are noncompetition clauses, also known as restrictive covenants. These clauses, placed in the contract in order to protect the employer, usually prohibit the employee from soliciting the employer's patients when the employment relationship ceases. In addition, noncompetition clauses often prohibit the employee from practicing for a specified period of time within a certain geographic area.

Obviously, while such agreements may protect the employer, they can drastically reduce the employee's ability to earn a living should the employee leave the practice for any reason, including termination by the employer. Unfortunately, however, many physicians do not contest such clauses, mistakenly believing them to be unenforceable against physicians in the State of Florida. In the case of Jewett Orthopaedic Clinic v. White, 629 So. 2d 922 (Fla. 5th DCA 1993), however, the Fifth District Court of Appeal found that such agreements against physicians would be enforced.

Two statutes are applicable to noncompetition agreements. Former Section 542.33, Florida Statutes, applies to all noncompetition agreements entered into before July 1, 1996. Section 542.335, Florida Statutes, applies to all noncompetition agreements entered into after July 1, 1996.

Section 542.335, Florida Statutes, provides in general that a noncompetition agreement that is reasonable as to time, area, and line of business is valid. However, in order to be valid, a noncompetition agreement must be “reasonably necessary” to protect one or more “legitimate business interests” of the party seeking enforcement. If it can be shown that it is necessary to protect one or more “legitimate business interests,” then, absent a strong defense, the courts must give those interests appropriate protection. The statute defines “legitimate business interest” to include:

1. Trade secrets.

2. Valuable confidential business or professional information that otherwise does not qualify as trade secrets.

3. Substantial relationships with specific prospective or existing customers, patients, or clients.

4. Customer, patient, or client goodwill associated with:

    a. An ongoing business or professional practice, by way of trade name, trademark, service mark, or "trade dress";

    b. A specific geographic location; or

    c. A specific marketing or trade area.

5. Extraordinary or specialized training.

A restrictive covenant that is not supported by a legitimate business interest is unlawful and is void and unenforceable. Passalacqua v. Naviant, 844 So. 2d 792 (Fla. 4th DCA 2003).

A person seeking to enforce the restriction must plead and prove that the restraint is reasonably necessary to protect the legitimate business interest. On the other hand, the person opposing

enforcement must prove that the restraint is overbroad, overlong or otherwise not reasonable to protect legitimate business interests.

While "(t)he violation of an enforceable restrictive covenant creates a presumption of irreparable injury to the person seeking enforcement of a restrictive covenant," that irreparable injury is rebuttable. Section 542.335(1)(j), Florida Statutes. If the enforcing physician seeks injunctive relief, the physician must establish a legitimate business interest. Once a legitimate business interest is shown, there is presumption of irreparable injury. The burden then shifts to the breaching physician who has an opportunity to present counter evidence to prove the absence of an irreparable injury to the enforcing physician. This was exemplified in King v. Jessup, 698 So. 2d 339 (Fla. 5th DCA 1997). Here, the court held that the enforcing physician did not prove irreparable injury due to another physician's breach of a noncompetition covenant. Furthermore, the breaching physician presented counter evidence that successfully cast doubt on the existence of any irreparable injury.

In determining the enforceability of an agreement, a court may not consider any individual economic or other hardship that might be caused by the enforcement of the agreement. Section 542.335 (1)(g)1., Florida Statutes. The statute, however, does require the court to consider the effect of enforcement "upon the public health, safety, and welfare." This section seems to reenact the holding in Damsey v. Mankowitz, 339 So. 2d 282 (Fla. 3d DCA 1976).

At the same time, the court is required to consider "all other pertinent legal and equitable defenses." Section 542.335 (1)(g)3., Florida Statutes. One of these defenses is whether the person seeking the injunction to enforce the noncompetition clause has a clear legal right to the injunction. If the person seeking to enforce the noncompetition clause has not performed what the contract requires of that person, the courts have held that he does not have the right to enjoin the breach of the noncompetition clause. Bradley v. Health Coalition, Inc., 687 So. 2d 329 (Fla. 3d DCA 1997). In other words, if an employer materially breaches an employment agreement, the employee may treat the breach as a discharge of his liabilities under the contract. Bradley. See also, Benemerito & Flores, M.D.'s P.A. v. Roche, 751 So. 2d 91 (Fla. 4th DCA 1999).

In an effort to provide some guidance to both individuals and businesses, the Legislature enacted several "safe harbors." Section 542.335(1)(d), Florida Statutes. Included among the "safe harbors" are the following rebuttable presumptions:

1. In the case of a restrictive covenant sought to be enforced against a former employee, agent, or independent contractor, and not associated with the sale of all or a part of a business or an equity interest in a professional practice, a court will presume reasonable in time any restraint six months or less in duration and will presume unreasonable in time any restraint more than two years in duration.

2. In the case of a restrictive covenant sought to be enforced against the seller of all or a part of a business or professional practice, a court will presume reasonable in time any restraint three years or less in duration and will presume unreasonable in time any restraint more than seven years in duration.

3. In determining the reasonableness in time of a restrictive covenant predicated upon the protection of trade secrets, a court will presume reasonable in time any restraint of five years or less and will presume unreasonable in time any restraint of more than 10 years.

Under former Section 542.33(2)(a), Florida Statutes, restrictive covenants entered into before July 1, 1996, generally were held to be valid within the State of Florida if they were "reasonable." Because of the ambiguous language contained in the statute, however, it was often difficult to predict which agreements would be subsequently held valid. The statute failed to set forth any objective standards to be used to determine which agreements were "reasonable." If a

noncompetition agreement was “unreasonable”, it was held to be invalid. For this reason, restrictive covenants which prohibit future competition anywhere or in perpetuity often have been invalidated. With regard to physicians, enforcement of such covenants also will not be allowed if enforcement would jeopardize the public health. Damsey v. Mankowitz, 339 So. 2d 282 (Fla. 3d DCA 1976). For instance, if enforcement of a restrictive covenant left a community without a cardiologist, the court could find that such an agreement would jeopardize the public health, and therefore would hold the agreement invalid as against public policy.

Physicians should be reminded that restrictive covenants generally will be honored within the State of Florida. Therefore, those entering into employment contracts which contain such clauses must be aware of the significant implications of these agreements, which could severely restrict a physician's ability to earn a living in the community of their choice for several years.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

OPENING OR RELOCATING YOUR PRACTICE

Below is general contact information that will assist you in relocating a practice or opening a new practice. Please be advised that the information provided is not comprehensive and may not list everyone you need to contact.

BOARD OF MEDICINE

If you have moved, you should contact the Board of Medicine and provide them with your new address. You must provide this information in writing. When notifying the Board of Medicine regarding an address change, you should provide the physician address for the primary place of practice and include your licensure number with all correspondence. Write to: Department of Health, Florida Board of Medicine, 4052 Bald Cypress Way, BIN # CO3, Tallahassee, Florida 32300-1753; 850-245-4131.

NICA

All physicians licensed in Florida are required to pay into the NICA fund. To ensure that you receive all of your invoices, you should inform NICA of any change in address. NICA will process a change of address provided by telephone or written correspondence. All correspondence must include your licensure number. Write to: Neurological Injury Compensation Association (NICA), 2360 Christopher Pl # 1, Tallahassee, Florida 32308; 850-488-8191.

MEDICARE PROVIDER NUMBER

It is likely that you will be providing medical services to Medicare beneficiaries. In order to get paid by the Medicare program, you must complete an enrollment application with the Medicare Carrier – First Coast Service Options (FCSO). Medicare has several different forms. The form(s) that you will need to complete depend on your current situation. Please follow the links below to for obtaining the forms and information needed to enroll in Medicare.
Provider enrollment landing page:
http://medicare.fcso.com/Landing/139786.asp
Contact information for the provider enrollment division:
http://medicare.fcso.com/Contacts/238986.asp

MEDICAID PROVIDER NUMBER

To obtain a new Medicaid provider number or inform Medicaid of a change in address, contact the Agency for Health Care Administration at: 1-800-289-7799, select Option 4. The fax number for Re-Enrollment or Updates to Existing Provider Profiles is: 1-866-270-1497

BUSINESS LICENSE

Before opening your office, you will need a business license. This will be issued either by the city or county or both. Your local county medical society can provide you with the information on how to contact the city or county licensure units.

LABORATORY LICENSE

If you will be performing any laboratory services in your practice, you must comply with the Clinical Laboratory Act (CLIA) of 1998 and state licensure requirements. Please refer to the FMA article on laboratory licensure for additional information.

TAX IDENTIFICATION NUMBER

As an employer, you will need an Employer Identification Number (EIN) from the IRS. To apply for an EIN, you must fill out Form SS-4. If you will be providing "taxable" services or selling "taxable" items out of the office, you will need a state tax number. Please contact the Florida Department of Revenue at 800-352-3671 for further details.

PROFESSIONAL LIABILITY INSURANCE

In Florida it is not mandatory that all physicians purchase malpractice insurance. However, physicians are required to demonstrate financial responsibility. Please refer to the FMA articles on financial responsibility for additional information. The FMA endorses The Doctors Company as the vendor of choice for malpractice insurance and FMA members receive a discount. For more information please call: 800-741-3742.

DEA REGISTRATION UNIT

The DEA, Office of Diversion Control, Registration Unit, has a toll free number that registrants may call 24 hours a day. This number, 1-800-882-9539, is equipped with a voice mail system that may be used to request:

- New applications for registration;
- Renewal applications;
- Duplicate certificates of registration;
- DEA order forms; and
- Change of address

Callers may also opt to speak with a Registration Assistant during normal business hours (8:30 AM to 5:00 PM EST) or visit www.deadiversion.usdoj.gov for more information and forms.

NOTIFYING PATIENTS

If you are relocating your practice there are legal requirements regarding notifying patients – but only if you are becoming unavailable to your patients. See the FMA article entitled *Retiring/Closing/Relocating A Practice* if this applies to you.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

OSHA REQUIREMENTS FOR A MEDICAL OFFICE

The Occupational Safety and Health Administration (OSHA) provides health and safety guidelines for workplaces, including medical offices. The following list includes some critical requirements applicable to most health care employers. Specialty practices may be subject to different guidelines. The complete text of OSHA regulations can be found in Title 29 of the Code of Federal Regulations.

“Hazard Communication Standard”

This standard may also be referred to as the “employee right-to-know” standard. Employers must provide employees with information about the dangers of all potentially accessible hazardous chemicals and how to protect themselves in the event there is contact. The Hazard Communication Standard requires that employers must:

- Develop a written hazard communication program
- Compile a list of hazardous chemicals present in any capacity in the workplace
- Obtain a copy of the Material Safety Data Sheet (MSDS) for each chemical used or stored in the office
- Train employees on how to recognize the release of a hazardous chemical as well as familiarize employees with the hazard communication program

For a more comprehensive understanding of the Hazard Communication Standard, please see 29 C.F.R. § 1910.1200.

“Bloodborne Pathogens Standard”

This standard applies to any employer whose employees are reasonably at risk of coming in contact with blood or any other potentially infectious material. If subject to this standard, employers must:

- Develop and annually update a written exposure control plan
- Provide training to exposed employees
- Provide Hepatitis B vaccination, post-exposure evaluation, and follow-up to exposed employees at no cost
- Provide and ensure employees wear the proper personal protective equipment
- Color-code or label items such as sharps disposal boxes and containers for regulated waste, and contaminated laundry

For a more comprehensive understanding of the Bloodborne Pathogens Standard, please see 29 C.F.R. § 1910.1030.

“Ionizing Radiation Standard”

An employer is subject to this standard if there is an X-ray or other radiation emitting device within the facility. Employers must follow certain guidelines in order to reduce employee exposure to radiation.

- Radiation equipment and areas must be labeled with caution signs
- Employers must require their employees to wear personal radiation monitors

- Employers must take a survey of all types of radiation used in the facility

For a more comprehensive understanding of the Ionizing Radiation Standard, please see 29 C.F.R. § 1910.1096.

“Personal Protective Equipment (PPE)”

Employers must perform a “hazard assessment” of the “workplace to identify and control physical and health hazards.” In identifying potential hazards, employers must then determine the need for PPE. Once the appropriate PPE is provided to employees, employers are then required to train the employees in the use and care of PPE, maintain the quality of the PPE, and consistently review and update the PPE program.

“Medical and First Aid Standard”

“OSHA requires employers to provide medical and first-aid personnel and supplies commensurate with the hazards of the workplace. The details of a workplace medical and first-aid program are dependent on the circumstances of each workplace and employer.”

For a more comprehensive understanding of the Medical and First Aid Standard, please see 29 C.F.R. § 1910.151.

Exit Route, Emergency Action Plan and Fire Safety Standards

OSHA requires that exit routes are sufficient for the number of employees in a particular area. Additionally, employers must have visible evacuation routes posted.

OSHA recommends that employers have an Emergency Action Plan and a Fire Prevention Plan. If required by an OSHA standard, then the formulation of a plan is mandatory.

For a more comprehensive understanding of the Medical Exit Route, Emergency Action Plan and Fire Safety Standards, please see 29 C.F.R. § 1910.33 – 1910.39.

Other Considerations

There are many other hazards that employers should be conscientious of; keep in mind the following additional hazards. Lessen the chance of ergonomic injuries by properly lifting equipment and adjusting patients. Recognize areas prone to slips, trips, and falls as these are among the most prevalent hazards in a health care office. Minimize potential for exposure to tuberculosis and influenza. Finally, remember that all offices must display an OSHA poster in a space easily viewed by employees. The poster can be downloaded for free on the OSHA website.

Many other standards apply, to request the full OSHA guidelines, view sample programs or fact sheets please visit www.osha.gov or request information over the phone at (800) 321-OSHA (6742).

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: February 2013*

PAPERWORK PREPARATION FEE

There is no statute or administrative code provision that prohibits a physician from charging a fee for filling out paperwork requested by a patient. The FMA currently has a policy on this practice, which states that the FMA favors a policy that mandates that physicians be compensated appropriately for filling out forms that require a physician's time to review or complete. (HOD 1999; Res. 99-15).

The American Medical Association has an ethical guideline that states that "the attending physician should complete without charge the appropriate simplified insurance claim form as a part of service to the patient to enable the patient to receive his/her benefits. The charge for more complex or multiple forms may be made in conformity with local custom." *Opinion 6.07, AMA Council on Ethical and Judicial Affairs*.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: March 2013*

PATIENT-PHYSICIAN RELATIONSHIP

A dilemma which frequently faces physicians is determining when a patient physician relationship has been established. As most physicians are aware, the establishment of the patient physician relationship requires the physician to continue treating a patient until such time as the treatment is concluded or the patient has had both notice and time to obtain another health care provider. For this reason, many physicians are understandably reluctant to enter into a patient-physician relationship until such time as the physician is comfortable with both the patient and the physician's own ability to render appropriate care.

Case law throughout the country consistently states that a patient-physician relationship is not created until such time as both parties have entered into an actual or implied contractual relationship in which the physician agrees to render care to the patient. *See*, *Opinion 9.12, AMA Council on Ethical and Judicial Affairs.* As with any contract, this relationship requires both an offer and acceptance in order to be valid. Therefore, the creation of an appointment for a physician to examine a patient does not, in and of itself, create a patient-physician relationship. If, however, the physician agrees to "treat" a patient for a specific condition, the patient-physician relationship has been established.

Because of the state of the law, physicians and their office staff must be careful when scheduling appointments with new patients. Instead of stating that the physician will treat a new patient, office staff should only tell the new patient that the physician will see the patient to determine if the physician will undertake the case. Just as importantly, should the physician determine that he does not wish to treat the patient, he must make that decision known to the patient immediately, so that the patient does not assume that an implied contract has been reached. A physician, however, may not refuse to accept a person as a patient because of race, color, religion, national origin, or any other basis that would constitute "invidious discrimination." *Opinion 9.12, AMA Council on Ethical and Judicial Affairs.* In addition, a physician may not refuse to accept a patient because of a known disability of the patient or of a person with whom the patient is known to associate. Such an action would be in violation of the American with Disabilities Act, 42 U.S.C. §12182(a).

The creation of a patient-physician relationship is one which creates a series of important obligations for the physician, and is not a relationship to be entered into lightly. It is for this reason that a physician should take care to ensure that steps, such as those mentioned above, are taken to prevent the creation of such a relationship when the physician is not able or willing to honor each of the attached responsibilities.

As discussed above, once a patient-physician relationship is established, the physician is under an ethical duty to continue that relationship until it is properly terminated by giving the patient adequate notice. *Opinion 8.115, AMA Council on Ethical and Judicial Affairs.* A physician may terminate the patient-physician relationship at any time and is not required to communicate the reason for termination to the patient. The FMA suggests the following guidelines for terminating a patient:

(1) Notify patient <u>by certified letter</u> of the intent to withdraw care.

(2) Include the date at which the physician will no longer be available to provide care to the patient (the FMA recommends at least a two (2) week notification period).

(3) State in the letter that the physician will be available during the notification period to provide care on an emergency basis only.

(4) If the patient's condition requires continued treatment, the letter must state this fact and inform the patient of the importance of locating a new physician as soon as possible.

(5) The physician should notify the patient that copies of the patient's medical records will be made available (as required by law) to the patient or the patient's new treating physician.

(6) A copy of the termination letter should be placed in the patient's file.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

PHYSICIAN COLLECTIVE ACTION

As most physicians are aware, today's negotiations between individual physicians and huge managed care organizations are not conducted on a level playing field. Rather, the managed care organization which controls a substantial portion of the health care market possesses the economic leverage to force physicians to accept unfavorable terms in their contracts. In an effort to level the playing field, physicians have been struggling to organize themselves into groups to bargain more effectively with insurance giants by combining the economic power of otherwise competing providers. Although the unionization of physicians may appear to be a viable method of achieving this goal, physicians should be aware that federal law prohibits any collective activity on the part of most physicians unless certain strict criteria are met.

Under current federal law, only physicians who are employees fall within the labor exemption to the antitrust laws and may engage in collective bargaining. Self-employed physicians are not in an employment relationship, and, therefore, do not qualify for the labor exemption to the antitrust laws. Under the antitrust laws, physicians who are not economically integrated by sharing substantial financial risk may not collectively bargain, a principal tenet of any union activity. Unfortunately, the penalties for participating in any such collective activity in violation of federal antitrust laws can be substantial. Not only may the collective organization be subject to fines and penalties, but the individual physicians comprising the organization also would be subject to penalties ranging from fines and jail sentences, to prohibition against any future partnerships. It is therefore crucial that physicians ensure that any organization which attempts to negotiate on their behalf is either sufficiently economically integrated, or does not assume the authority to negotiate on behalf of an unintegrated group of physicians.

Despite the dangers associated with unionization, many of the goals enunciated by current physician unions are ones shared by the Florida Medical Association and the American Medical Association. It is for this reason that the FMA House of Delegates, at the 1998 Annual Meeting, adopted Resolution 98-13 which directed the FMA to support legislation proposed in the U.S. Congress by Representative Tom Campbell (R-California), entitled “The Health-Care Coalition Act,” which stipulates that: “Any group of health care professionals, negotiating with a health maintenance organization, insurer, or other payer, shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws accorded to members of a bargaining unit recognized under the National Labor Relations Act. Similarly, as a result of a resolution submitted by the FMA in 1997, the AMA, at its June 1997 Annual Meeting, adopted Resolution 240 calling for the removal of restrictions for physicians to form collective bargaining units “in order to negotiate reasonable payments for medical services and to compete in the current managed care environment including the drafting of appropriate legislation.”

In this changing health care environment physicians recognize the need to work together. However, until the current antitrust laws are changed to allow full collective negotiations on the part of independent self-employed physicians, physicians should be wary of joining any organization which may subject the physician to an FTC investigation.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

PHYSICIAN TREATMENT OF RELATIVES

A delicate issue among physicians is whether it is morally, ethically, and legally acceptable to treat one's relatives. While some states have statutes regulating a physician's treatment of relatives, friends, and self, Florida is silent on the issue. The American Medical Association (AMA) advises against the treatment of relatives except for in emergency situations, isolated settings, or for routine care for minor problems. *Opinion 8.19, AMA Council on Ethical and Judicial Affairs*.

There are some inherent dilemmas with the treatment of immediate family members. Close relatives may withhold crucial information on sensitive issues, a physician's confidence may be compromised by emotions that result from treatment of a loved one, there are higher risks for privacy violations, and strained relationships may develop in both the physician-patient relationship and in the family relationship.

Despite these risks, the reality is a vast majority of doctors in some way diagnose, treat, or prescribe medication for a family member. Since this is the case, it is important for physicians to take certain steps in order to protect themselves from liability. This can be done by creating a proper written record for all diagnoses, treatments, procedures, etc. Encourage relatives to establish a general practitioner and recognize that relative-patients have the same rights as nonrelated patients concerning informed consent and alternative treatments. Also keep in mind that it is legal in Florida for physicians to prescribe medications to family members, but physicians can never self-prescribe controlled substances.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: April 2013*

POLITICAL INVOLVEMENT BY PHYSICIANS

Physicians often refuse to sign letters of endorsement, distribute candidate literature in their offices, or otherwise publicly participate in the political process. Unfortunately, many physicians, despite the efforts of the FMA, still have the mistaken notion that involvement in political matters is unethical and/or illegal. In reality, physicians not only have a right to participate in the political process, they have a duty to do so as well.

Principle VII of the American Medical Association Principle of Medical Ethics requires physicians to "**recognize the responsibility to participate in activities contributing to an improved community**." Principle III requires that physicians "**recognize the responsibility to seek changes in those requirements [of the law] which are contrary to the best interest of the patient**." Rather than insulating a physician from the political process, these principles require a physician to keep well informed about current political questions and to exercise the full scope of their political rights as citizens.

In addition to the rights and privileges of free political speech shared by all Americans, physicians have an enhanced duty to work for the reform and enactment of laws that affect access to medical care, quality of medical services, and public health. It is natural that in fulfilling this duty, physicians will express their positions on political issues and attempt to solicit the support of their patients and their families. These conversations are a fundamental part of political freedom. However, political activism must be undertaken with great care in order to not interfere with the physician-patient relationship or exploit the medical authority of the physician by imposing upon vulnerable patients or family members. Physicians should appropriately exercise their discretion when deciding on the time and place to exercise their political rights.

The AMA's Council on Ethical and Judicial Affairs has recognized that it is without doubt that physicians have the right to engage in political activity, be it conversations with patients, signing letters of endorsement, or simply providing campaign literature in a physician's office. While neither the law nor ethical considerations prohibit physicians from exercising such rights, physicians should always be mindful that patient care is their essential mission and it should not be affected by their patients' decisions to support or not support particular political positions, parties, or candidates.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: March 2013

PREGNANT MINORS' RIGHTS

For years, society has wrestled with the problems associated with teenage pregnancy. With the exception of the pregnant minor, however, no person is more involved with the issues surrounding this societal problem than the physician who treats the pregnant minor. Not only must the physician serve as both doctor and counselor to a young woman forced to make very mature decisions, but the physician must also take into account the myriad of laws concerning the rights of the pregnant minor and her parents.

In the past, Florida law required a minor wishing to terminate a pregnancy to obtain the consent of at least one parent. Both federal and state courts, however, found that such a requirement violated a women's "constitutional right to privacy", and therefore, ruled the offending statute, Section 390.001(4)(a), Florida Statutes unconstitutional. Poe v. Gerstein, 517 F.2d 787 (5th Cir. 1975), *aff'd* 428 U.S. 901; Scheinberg v. Smith, 482 F. Supp. 529 (D.Ct. 1979); In Re T.W., 551 So. 2d 1186 (Fla. 1989). Current law not only eliminates the need for parental consent, but Section 743.065(1), Florida Statutes, explicitly states, "an unwed pregnant minor may consent to the performance of medical or surgical care or services relating to her pregnancy by a hospital or clinic or by a physician licensed under Chapter 458 or 459, and such consent is valid and binding as if she had achieved her majority."

By combining this statute with the court's decision to overturn former Section 390.001(4)(a), Florida Statutes, the state has affirmed a pregnant minor's right to make her own medical decisions regarding her pregnancy, including the option of terminating the pregnancy, without the consent of the minor's parents.

In 1999, the Legislature attempted to scale back a minor's right to terminate her pregnancy by passing the "Parental Notice of Abortion Act." The Act required a physician who refers or plans to terminate the pregnancy of a minor to give 48 hours actual notice prior to the procedure to one parent of the minor or her legal guardian. The constitutionality of the Act was challenged immediately, and in North Florida Women's Health v. State, 866 So.2d 612 (Fla. 2003), the Florida Supreme Court declared the Act unconstitutional. The Court, relying on In Re T.W., 551 So. 2d 1186 (Fla. 1989), held that the Act violated the right to privacy under Florida's Privacy Amendment.

In 2004, however, the voters in Florida approved the "Parental Notification of a Minor's Termination of Pregnancy" Amendment to Article X, Section 22 of the Florida Constitution. The amendment provides that the Florida Legislature is authorized to require, by general law, for notification to a parent or guardian of a minor before the termination of the minor's pregnancy. The 2005 Legislature proceeded to enact Section 390.01114, Florida Statutes, to implement the amendment. The statute requires that the physician performing or inducing a termination of a pregnancy of a minor must provide notice, either directly in person or by telephone, to a parent or guardian of the minor at least 48 hours before the performance of the termination of pregnancy.

The notice must be documented in the minor's medical records. The statute allows the referring physician to provide the required notice. In that event, the physician performing the termination of pregnancy must receive a written statement from the referring physician certifying that the notice

has been given. If the notice is provided by telephone, the physician must actually speak with the parent or guardian and must record in the minor's medical record the name of the parent or guardian, the telephone number dialed, and the date and time of the telephone call. Notice to the parents or guardian is not required if:

- In the physician's good-faith judgment, a medical emergency exists and there is not enough time to provide the required notice;
- Notice is waived by the person who is entitled to notice;
- Notice is waived by the minor who is or has been married or has had the disability of nonage removed;
- Notice is waived by the parent because the patient has a minor child dependent on her.

The statute provides that failure to comply with the notice requirement constitutes grounds for disciplinary action. The statute also provides a procedure whereby the minor may petition a court to waive the notice requirements.

While it is clear that current Florida law allows a pregnant minor to consent to all medical treatment with regard to her pregnancy, including the potential termination of the pregnancy, the Florida law on whether parents are entitled to medical records concerning such care is less certain. Although Section 456.057, Florida Statutes, allows a legal representative, such as a parent of a minor, to obtain medical records, it must be remembered that Florida courts have found that a pregnant minor has a constitutional right to privacy. In Re T.W., 551 So. 2d 1186 (Fla. 1989). In that case, the Florida Supreme Court held that the right of privacy under Florida's Privacy Amendment extends to "every natural person." The Court found that minors are natural persons in the eyes of the law and "constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, possess constitutional rights." This holding, combined with North Florida Women's Health and existing Florida law which allows a pregnant minor to consent to such medical services without the permission of parents, implies that the medical records concerning a pregnant minor should not be disclosed to the minor's parents, except with the consent of the minor.

PRESCRIBING STANDARDS VIA TELEMEDICINE

Physicians should be aware of the laws relating to prescribing for patients that they do not see in person, otherwise known as telemedicine. Telemedicine is defined as the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service. Rule 64B8-9.0141, F.A.C., issued by the Florida Board of Medicine, further delineates the standards for telemedicine practice:

- The standard of care shall remain the same regardless of whether a Florida licensed physician or P.A. provides health care services in person or by telemedicine.
- Providers of telemedicine are responsible for the quality of the equipment and technology employed and are responsible for their safe use. Telemedicine equipment and technology must be able to provide, at a minimum, the same information to the provider which will enable them to meet or exceed the prevailing standard of care.
- Controlled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed under Ch. 395, F.S.
- Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician's professional practice.
- Providers of telemedicine shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless these elements have been met:
    - A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.
    - Discussion between the provider and the patient regarding treatment options and the risks and benefits of treatment.
    - Maintenance of contemporaneous medical records.
- The practice of medicine by telemedicine does not alter any obligation of the physician or the P.A. regarding patient confidentiality or recordkeeping.
- A physician-patient relationship may be established through telemedicine.

This rule does not apply in the following circumstances:

- Consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data.
- Emergency medical services provided by emergency physicians, emergency medical technicians (EMTs), paramedics, and emergency dispatchers.
- When a physician or P.A. is treating a patient with an emergency medical condition that requires immediate medical care.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. Last Update: August 2016

PRESCRIPTION RENEWALS

In the course of a physician's normal practice, it is common for the physician to treat patients whose conditions require continuous medication, while not necessitating actual repeated office visits to the practitioner. In these instances, expediency dictates that the physician merely renew prescriptions of the needed medication without wasting the time of the patient or physician by scheduling an office visit. In addition, the physician, having a desire to be compensated for the ongoing care of the patient, is tempted to code the service in such a way that the physician will be reimbursed by the patient or third party payors for his services. In many instances, the physician will bill this service as an office visit, notwithstanding the practitioner's failure to have personally examined the patient.

Unfortunately, the practice of charging for routine renewing of prescriptions exposes the physician to a myriad of legal and ethical problems. Although it is appropriate for a physician to charge a nominal fee for renewing prescriptions, several factors must be considered before the physician renews any medication, especially if the physician wishes to charge for this service.

Even if the physician chooses not to charge, the prescription of any medication without an office visit, even one which previously has been administered without incident to the patient, poses several practical concerns for the physician. For instance, courts in many states have found that physicians who routinely call in prescriptions for patients without actually examining the patients may be found guilty of excessive prescribing and prescribing outside the course of their practices, both of which would be a violation of Section 458.331(1)(m), Florida Statutes, (see e.g., Eaves v. Board of Medical Examiners, 467 N.W.2d 234 (Iowa 1991) see also U.S. v. Moore, 423 US 122(1975)) and could result in the loss of the physicians' licenses. In addition, the granting of prescriptions without actual examination exposes the physician to the threat of a malpractice action for which the physician would have little defense, as an actual examination was not made to support the doctor's prescription.

Nor is a physician immune from malpractice and overprescription claims due to the physician's reliance on the opinion of another medical professional. For instance, a locum tenens physician may not assume that a prescription made by the absent physician should be renewed. Rather, the covering physician should examine the medical record to determine if the prescription is suitable for a chronic condition which is unlikely to change before renewing a prescription for such medication. If, however, the prescription for which a renewal is asked is for a condition which may have abated since the issuance of the original prescription, the locum tenens should require an office visit by the patient before renewing the prescription.

The potential problems are multiplied when a physician charges for this service. In fact, in addition to the potential pitfalls noted above, physicians who routinely prescribe controlled substances to patients while charging a flat fee for such prescriptions have been found guilty of trafficking in narcotics (see e.g. U.S. v. Larsen, 507 F.2d 385 (9th Cir. 1974)) and sentenced as felons.

From an ethical perspective, the practice of charging an amount equal to that of an office visit for the mere prescribing of a drug could well be viewed as unethical under standards prescribed by the American Medical Association Council on Ethical and Judicial Affairs. Under the AMA's Council on Ethical and Judicial Affairs Opinion 6.05, "[a] fee is excessive when after review of the facts a person knowledgeable to the current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee." In determining whether a fee is excessive, the trier of fact would be asked to consider "the difficulty and/or uniqueness of the services performed, and the time, skill and experience required." Obviously, in the case of the routine filing of a prescription, the time and skill required would only justify a minimal fee. In most cases, the imposition of a charge equal to a full office visit may well be considered excessive.

As shown above, for purposes of quality medical care and ethics, it is unadvisable for a physician to charge a patient for an office visit when the only service offered is the renewing of a prescription. Yet the problems associated with such a practice are compounded when a third party payor is involved. The most common problem associated with such a practice is that of "upcoding". In a typical "upcoding" scenario, a physician, in an effort to be reimbursed, may well attempt to bill for a prescription renewal under CPT-4 code 90040 (brief examination or treatment). In actuality, however, such services should be coded as no more than 90030 (minimal service), as the latter CPT code does not require the actual examination by a physician. Such differences may seem trivial, but they certainly were not trivial to a Dr. Larm, whose upcoding of this type resulted in criminal charges being filed against him by Medicare, charges for which he has found guilty and which were upheld by federal appeals courts (see U.S. v. Larm, 824 F.2d 780, (9th Cir. 1987)).

Just as importantly, the practice of billing an insurance company for an office visit which did not, in fact, occur would constitute insurance fraud under Section 817.234, Florida Statutes. Under this statute, any physician who asks for reimbursement by providing the insurer with false or misleading information is guilty of a third degree felony, punishable by five years in prison and a fine of $5,000. Moreover, any violation of this statute would be reported to the Board of Medicine, which would take appropriate action against the provider's license.

For all of the above reasons, a physician should carefully consider whether even a routine prescription should be renewed without a thorough examination on the part of the physician. Even if the physician decides to grant the renewal, however, he or she must carefully consider not only the appropriate charge, but how to code such a service. In no event should a physician charge a fee equivalent to that associated with an actual examination when the patient is not actually seen by the doctor.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

PRIVATE CONTRACTING AND MEDICARE

People who choose to participate in Medicare receive not only coverage but also protection from paying excessive fees for physician services. Medicare enrollees have always been free to pay physicians for any service Medicare does not cover.

When Medicare covers a service, Medicare pays the bill. When Medicare does not cover a service, Medicare enrollees can pay the bill out of their own pocket. When Medicare coverage is uncertain in a particular case, a physician can provide the service, submit the bill, and notify the enrollee in writing that if it is denied, the enrollee will pay the bill. Also the patient cannot bill Medicare.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 allows physicians to enter into "private contracts" with Medicare enrollees. The law allows physicians to contract with Medicare enrollees and set their own fees for services covered by Medicare. These private contracts must state explicitly that the patient must pay the entire fee charged by the physician for these services, the physician may not bill Medicare, and the contracts may not be signed in emergencies.

Physicians who want to privately contract with Medicare enrollees for services covered by Medicare must declare that they will not bill Medicare for any services for two years. This ensures that all Medicare enrollees are treated equitably and are informed in advance whether a doctor accepts Medicare or will expect the patient to pay the entire bill. It also prevents private contracts from creating a new opportunity for fraud by unscrupulous physicians who could attempt to double bill both Medicare and the patient.

MEDICARE ENROLLEES CAN STILL BUY SERVICES NOT COVERED BY MEDICARE.

This does not change under the new law. Payment for anything not covered by Medicare, such as routine annual physicals or screening tests for prostate cancer, is a matter between patient and doctor. Physicians who bill Medicare for services Medicare does cover may continue to charge their usual fee-for-service amount to Medicare enrollees for services Medicare does not cover.

THE NEW LAW AFFECTS ONLY SERVICES COVERED BY MEDICARE.

All physicians may provide services not covered by Medicare to Medicare enrollees without private contracts. Physicians who provide Medicare enrollees with services not covered by Medicare can continue to charge Medicare enrollees for these services and can continue to participate in Medicare.

THE NEW LAW AFFECTS ONLY PEOPLE WHO CHOOSE MEDICARE.

Medicare coverage of physician services is a voluntary program with a monthly premium paid by eligible individuals who choose to enroll. For those who do not choose to enroll in Medicare, physicians may charge their usual fee for any service without any effect on the physicians' Medicare status.

THE NEW LAW EXPANDS OPTIONS FOR PHYSICIANS.

Under private contracts, physicians who opt out of Medicare can charge Medicare enrollees any amount for services covered by Medicare. Physicians must, however, treat all Medicare enrollees alike. If they establish private contracts with some, they cannot bill Medicare for others. Medicare enrollees, however, may privately contract with a physician for some services and still use Medicare for services from other physicians who do bill Medicare.

PHYSICIANS CAN PROVIDE CARE WHEN COVERAGE IS UNCERTAIN.

As always, if a physician who bills Medicare is uncertain whether a service will be covered by Medicare, the physician can provide the service without a private contract. The physician can simply provide the enrollee with an "advance beneficiary notice" stating that the service may not be covered by Medicare and that the enrollee will have to pay for the service in full if Medicare does not pay the bill.

For answers to questions, call 1-800-MEDICARE or visit www.medicare.gov.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last update: October 2005*

PROFESSIONAL COURTESY

As members of the medical community, physicians are blessed to be part of a profession in which mutual respect and courtesy are the norm. One of the ways in which this collegiality often has been expressed has been through the extension of the professional courtesy by medical providers to others within the profession, as physicians frequently provide professional services without charge or for a greatly reduced fee to other medical professionals.

With the passage of so-called "self-referral" and “anti-kickback” laws on both federal and state levels, however, many physicians have been forced to reevaluate their extension of professional courtesy. Until recently, however, it was unclear whether the extension of professional courtesy by a physician to another physician violated those same laws. Due to the release of the Guidance Statement by the OIG in September 2000 and the recent publication of the final Stark II regulations, much of the uncertainty surrounding professional courtesy is gone.

The Health Insurance Portability and Accountability Act (also known as the “Kennedy-Kassebaum Law” or “HIPAA”) signed into law on August 21, 1996, and the Guidance Statement issued by the OIG in September 2000, resolved the question as to the “anti-kickback” law. The Kennedy-Kassebaum Law amended the federal anti-kickback act to specifically include free services within the definition of “remuneration.” As such, extending professional courtesy through providing free care to another physician could be viewed as a violation of the anti-kickback law, if there is any likelihood that the other member may refer (or already had referred) a patient to the physician.

In October 2000, the OIG issued a Guidance Statement, which addressed whether professional courtesy arrangements may violate the fraud and abuse laws. In that Statement, the OIG stated that whether professional courtesy arrangements violate the law are determined by two factors: (1) how the recipients of the professional courtesy are selected; and (2) how the professional courtesy is extended. In an effort to clarify its policy on professional courtesy, the OIG set forth the following observations for physicians to consider:

- A physician’s regular and consistent practice of extending professional courtesy by waiving the entire fee for the service rendered to a group of persons (including employees, physicians, and/or family members) may not violate any of the fraud and abuse laws as long as membership in the group receiving the courtesy is determined in a manner that does not take into account directly or indirectly any group members ability to refer to, or otherwise generate federal health care program business for the physician.
- A physician’s regular and consistent practice of extending professional courtesy by waiving otherwise applicable copayments for services rendered to a group of persons would not implicate the anti-kickback statute as long as the membership in the group is determined in a manner that does not take into account directly or indirectly any group member’s ability to refer to, or otherwise generate federal health care program business for the physician.
- Any waiver of copayment practice, including that described in the preceding paragraph, does not violate the prohibition against inducements to beneficiaries (42 U.S.C. §1320a-7a(a)(5)) if the patient for whom the copayment is waived is a federal health care program beneficiary who is not financially needy.

On March 26, 2004, the Center for Medicare and Medicaid Services (“CMS”) issued an interim final rule, which addressed the self-referral law and created regulatory exceptions to the self-referral law for financial relationships that CMS determines do not pose a risk of fraud or abuse.

The rule became effective on July 26, 2004. One of the exceptions created by the rule deals with professional courtesy. CMS defined "professional courtesy" in 42 C.F.R. §411.351 to mean the "provision of free or discounted health care items or services to a physician or his or her immediate family members or office staff." To qualify for the new exception, 42 C.F.R. §411.357(s) requires that the arrangement meet the following six conditions:

- The professional courtesy is offered to all physicians on the entity's bona fide medical staff or in the entity's local community without regard to the volume or value of referrals or other business generated between the parties;
- The health care items and services provided are of a type routinely provided by the entity;
- The entity's professional courtesy policy is set out in writing and approved in advance by the governing body of the health care provider;
- The professional courtesy is not offered to any physician (or immediate family member) who is a Federal health care program beneficiary, unless there has been a good faith showing of financial need;
- The professional courtesy arrangement does not violate the anti-kickback statute or any Federal or state law or regulation governing billing or claims submission.

Even though it is now much clearer as to when a physician may extend professional courtesy to another person, physicians must exercise caution before extending professional courtesy discounts to other members of the profession to ensure that the arrangement does not violate either the self-referral laws or the anti-kickback laws. Whether a particular professional courtesy arrangement violates either the self-referral laws or the ants will turn on the specific facts presented. It is indeed a sad reflection of our society when the provision of a courtesy may entitle a benefactor to no more than a series of legal entanglements.

Of course, these pieces of legislation do allow professional courtesy discounts to be given to those colleagues who have not and will not ever refer patients to the discounting physician. Even in this case, however, the provider of services may not bill the patient's insurance company for the usual cost of such a visit if a professional courtesy is to be given, as such a practice would constitute a fraudulent insurance activity under state law. Moreover, if the extension of professional courtesy is a common practice within the office, the filing of any insurance may be troublesome, as the insurance company properly may argue that any fee requested is not the physician's "usual and customary" fee for a service provided to a physician.

Extensive research has failed to reveal any instances where a physician has been prosecuted by either the OIG or the Department of Justice based on the extension of professional courtesy to another physician. The AMA has been previously advised informally by the OIG that the OIG is unlikely to initiate a fraud or abuse case investigation related to the traditional act of professional courtesy. However, the issuance by the OIG of its Guidance Statement concerning professional courtesy arrangements may indicate a change in the OIG's position.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: February 2013

PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS

PART I - OPTIONS FOR MEETING FINANCIAL RESPONSIBILITY REQUIREMENTS

Every Florida licensed physician is required to comply with the financial responsibility requirements of Section 458.320, Florida Statutes. This statute requires a physician to demonstrate to the Board of Medicine and the Department of Health that he or she is financially able to pay claims arising out of the rendering or failure to render medical care or services. The law provides the physician with the following options:

- Obtain and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer, from a surplus lines insurer, from a risk retention group, from the Joint Underwriting Association, or through a plan of self-insurance as provided in s. 627.357 (Self-insurance is discussed in Part II). If the physician has hospital privileges the amounts are $250,000/$750,000 respectively.
- Maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified above.
- Obtain and maintain an unexpired, irrevocable letter of credit in an amount not less than $100,000 per claim, with a minimum aggregate available of credit of not less than $300,000. The letter must be payable upon presentment of a final judgment awarding damages or upon presentment of a settlement agreement. The letter must be nonassignable and nontransferable and must be issued by a bank doing business in Florida. If the physician has hospital privileges the amounts are $250,000/$750,000 respectively.
- Certain physicians are exempt from demonstrating one of the abovementioned methods of financial responsibility. Exemptions are discussed in Part III.

It is important to note that none of the options listed above may be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

If a physician chooses to carry professional liability insurance, the statute requires the physician to notify the Department of the cancellation or nonrenewal of his or her insurance. The physician must demonstrate to the Department that he or she has chosen a new method of demonstrating financial responsibility. If the physician is unable to demonstrate this to the Department, the Department must suspend the physician's license until he or she is able to do so.

A physician is subject to the Board's disciplinary process if he or she makes any deceptive, untrue or fraudulent representations with respect to any requirements relating to the financial responsibility requirements. <u>All physicians must notify the Department of any change in how they meet the financial responsibility requirements.</u>

PART II - THE DECISION TO SELF-INSURE

A physician in Florida may choose to meet the financial responsibility requirements set forth in Section 458.320, Florida Statutes by "self-insuring." But it is important for the physician to know what this involves. A physician who self-insures must be in compliance with Section 627.357, Florida Statutes. A physician or group of physicians is authorized to self-insure upon obtaining approval from the office and upon the following conditions:

- Establishment of a Medical Malpractice Risk Management Trust Fund to provide coverage against professional malpractice liability

- Employment of professional consultants for loss prevention and claims management coordination under a risk management program

Other important guidelines to remember include:

- The liability of each member for the obligations of the fund is individual, several, and proportionate, but not joint.
- Each member has a contingent assessment liability for payment of actual losses and expenses incurred while the member's policy was in force.
- If one or more members fail to pay an assessment, the other members are liable on a proportionate basis for an additional assessment. The fund, on behalf of said members who paid the additional assessment, shall institute legal action to recover the assessment from members who failed to pay it.
- If the assets of a trust fund are at any time insufficient to comply with the requirements of law or if a judgment against the fund has remained unsatisfied for 30 days, the trust fund must immediately make up the deficiency or levy an assessment upon the members for the amount needed to make up the deficiency. If the trust fund fails to make such an assessment, the office shall order the fund to do so. If the deficiency is not sufficiently made up within 60 days after the date of the order, the fund is deemed insolvent and grounds exist to proceed against the fund.

There are many considerations to take into account when deciding whether to self-insure. Generally, physicians take this route when medical liability insurance is unavailable or unaffordable. It is important to seek legal guidance before choosing to self-insure.

PART III - AN OPTION YOU MIGHT NOT HAVE CONSIDERED

Florida law provides another option that is often overlooked. A physician may well fall under Section 458.320(5)(a)-(g) which allows physicians to meet the financial responsibility requirement without holding liability insurance. Most people consider this an exemption for physicians who only work 20 hours a week or less. But upon careful reading of the statute a physician may find an applicable exemption. Subsections (5)(a)-(e) state that a physician is exempt from the requirements set forth above if he or she meets *one* of the following criteria:

- Practices exclusively as an employee of the Federal or State government
- Holds an inactive license
- Holds and practices pursuant to a limited license
- Only practices in conjunction with his or her teaching duties at an accredited medical school or
- Is not practicing medicine in this state

Subsections (5)(f)1.-7. state that a physician is exempt from the financial liability requirements if he or she meets *all* of the following criteria:

- Has practiced for more than 15 years
- Practices no more than 1,000 patient contact hours per year
- Has no more than 2 claims in the last 5 years of more than $25,000
- Has no convictions related to the practice of medicine
- Has had no serious actions against their license (including any action resulting in a fine $500 or greater)
- The licensee has submitted to the department an affidavit affirming compliance with these requirements and
- Posts a notice to patients in the office regarding not carrying professional liability insurance or

provide a written statement that must state the following:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

While most doctors work more than 1,000 hours per year, the question to be asked is: how many of the hours worked include patient contact hours? If your practice amounts to less than 1,000 hours of patient contact per year, you may want to look further at this option.

Section 458.320(5)(g) further allows a physician to be exempt from carrying liability insurance if the physician agrees to meet the following criteria:

- Upon the entry of an adverse final judgment in a professional liability case the physician must pay the plaintiff the lesser of the amount of the judgment *or* $100,000 (if the physician does *not* have hospital privileges) *or* $250,000 (if the physician *does* have hospital privileges) within 60 days of the judgment becoming final.
- If the judgment is unsatisfied, the licensee will be subject to discipline unless if within 30 days the physician:

1. Shows proof of satisfied judgment or
2. Furnishes proof of time appeal with either a copy of a supersedeas bond or an order from the court staying execution on the judgment pending disposition of the appeal.

Once the Department of Health becomes aware of an unpaid judgment, it must notify the physician that he or she is subject to disciplinary action if he or she does not meet the above listed requirements. The Department must immediately suspend the license of a physician if he or she is unable to demonstrate that one of these conditions has been met. The Department then has 30 days in which to file charges against the physician. The case then proceeds through the disciplinary system. <u>The license must stay suspended until the required amounts set forth above are paid by the physician.</u> Once the judgment is met, the restrictions on the physician's license must be removed.

In addition to the above requirements the physician must post a sign in his or her reception area or provide the statement to all patients stating:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

*It is important to remember that choosing this option does not release the doctor from having to pay any judgments entered against him or her.

While this option is certainly not for everyone, it may be beneficial for some physicians who are being forced by the current medical liability crisis to make difficult decisions. Keep in mind that it

is always a good idea to obtain individualized legal advice when making these decisions. Additionally, the physician may submit to the department a request for an advisory opinion regarding his or her qualifications for exemption.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

QUESTIONS COMMONLY ASKED BY PHYSICIANS

1. **I recently received a subpoena from an attorney for medical records. It was not issued by the court but rather was only signed by the attorney. Do I have to comply?**

   Answer: Yes. The Florida Rules of Civil Procedure provide that an attorney can sign a subpoena - they do not have to be issued by the court.

2. **Does a doctor have to have a staff member present when he is conducting a physical examination of a member of the opposite sex?**

   Answer: No. There is no statute or administrative code provision that requires an individual be present in addition to the doctor during such examination. However, it is strongly recommended that physicians make this a standard practice given the current climate concerning sexual harassment and related lawsuits. Having a staff member present during such examinations is good practice in that it can provide verification as to whether proper procedures were followed should a problem later arise. The AMA's Council and Ethical and Judicial Affairs recommends that the option of having a chaperone present be given to the patient.

3. **May I treat a minor without parental consent?**

   Answer: The general rule is no, but in certain circumstances, parental consent is not required. Those situations involve sexually transmitted diseases, pregnancy, emergency care, mental health and alcohol/drug abuse. In the case of sexually transmitted diseases, the physician is not allowed to notify the parents, i.e. by sending a bill.

4. **May I charge interest on an unpaid bill?**

   Answer: Yes, but at no more than the maximum rate set by the state of Florida (18%). In addition, the patient needs to be notified in advance of the interest and other charges by such means as the posting of a notice in the waiting room, the distribution of leaflets, etc. AMA ethical guidelines urges physicians who charge interest to use compassion and discretion in hardship cases.

5. **Must I supply an interpreter at the request of a deaf patient?**

   Answer: Not necessarily. A physician's office is required to provide whatever "auxiliary aids" are required for effective communication with a hearing-impaired person. This requirement is a flexible one. You are not required to hire an interpreter in every situation. What is reasonable depends on the circumstances, as long as there is "effective communication." You should consult with the patient before providing a specific auxiliary aid. In lengthy or complex situations, a qualified interpreter is necessary. In other types of routine matters, including a routine office visit, a pad of paper and a pen may be acceptable. A tax credit is available to physician offices to help offset the cost of an interpreter.

6. **What notification requirements do I have to my patients when I close my practice?**

Answer: Florida law provides that the records owner can either place an advertisement in the newspaper advising patients of the change in practice and the location of the medical records or can provide this information to each patient in writing. This must be done 30 days in advance. You must also notify the Board of Medicine of any change of address.

7. **What may I charge for a deposition or expert witness fee?**

Answer: There is no set rate to go by. The law provides that a physician testifying as an expert witness is entitled to a reasonable fee, with what is reasonable decided on a case by case basis. The average going rate appears to be $250-300 per hour with more for certain specialties. In worker's compensation cases, however, you are limited to $200 per hour if you treated the patient and $200 per day otherwise.

8. **A physician requested medical records on a patient that has an unpaid balance. Can I withhold the records until the patient pays his account?**

Answer: No. You must provide the records upon request, regardless of whether the patient has an outstanding balance concerning the services you have provided.

9. **Can I charge the physician a copying fee?**

Answer: Yes, at the same rate you charge the patient - $1.00/pg for the first 25 pages and $.25/pg for each page thereafter. Unlike for services rendered, you can condition release of the records upon payment of copying charges.

10. **When a patient requests a copy of his medical records, am I allowed to or do I have to provide copies of records generated by other physicians?**

Answer: You must provide copies of everything you have, including copies of records generated by other physicians. You can, however, charge the patient for all copies made.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

REPORTING IMPAIRED DRIVERS

Section 322.126, Florida Statutes, provides that "any physician, person, or agency having knowledge of any licensed driver's or applicant's physical or mental disability to drive or need to obtain or to wear a medical identification bracelet is authorized to report such knowledge to the Department of Highway Safety and Motor Vehicles. The report should be made in writing, giving the full name, date of birth, address and a description of the alleged disability of any person over fifteen years of age having mental or physical disorders that could affect his or her driving ability." Such reports are confidential and the reporting physician will incur no liability, either civil or criminal.

Please note that a report under this section is voluntary. While a physician is authorized to report such disability, the statute does not place a mandatory obligation upon him or her to do so. The decision as to whether to file a report is left up to the individual physician.

The Medical Reporting Form can be found at: https://www.flhsmv.gov/forms/72190.pdf

Physicians can send these written reports, to:

Division of Motorist Services
Attn: Medical Review Section
Neil Kirkman building, MS 86
Tallahassee, Florida 32399-0500

The bureau prefers for the reports to be on the physician's letterhead and the patient information listed above should be included. All reports should be sent to the Tallahassee address above – the bureau will then forward the information to the appropriate local office who will contact the driver. The driver will be either re-examined by the driver's license office or the driver will have to provide medical documentation that there is no need for a re-examination.

For further information, call the bureau at (850) 617-3814.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

RETIRED LICENSES AND LIMITED LICENSES

In 2005, the Florida legislature added new language to Section 456.036, Florida Statutes, which allows any Florida health care practitioner, including MDs and DOs, to convert their license to "retired" status. This allows a physician to keep his or her Florida license, but not actively practice. Under this status, a physician does not have to meet the requirement of active practice, does not have to pay biennial fees and does not have to take the required continuing medical education. They may not practice but will be able to retain their Florida license. A physician requesting to come off of retired status and return to active practice will have to pay renewal fees and take CME hours and will also have to demonstrate competency to return to practice if they have been retired more than 5 years. A physician can remain in retired status indefinitely.

A physician does not have to be retired or intend to retire from the practice of medicine to obtain a limited license. However, if a physician is not fully retired in all jurisdictions, he can only use the limited license for noncompensated practice. To obtain a limited license, a physician must submit to the Board of Medicine, with an application and a $300.00 fee, an affidavit stating that he has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license. The application fee will be waived if accompanied by a notarized statement from the physician’s employer stating that he will not receive monetary compensation for his service involving the practice of medicine.

If the physician wishing to obtain a limited license has not been involved in the active practice of medicine in the past 3 years, supervision by the full time director of the county public health unit or licensed physician is required for a period of 6 months, unless the Board determines that a shorter time period is sufficient.

The recipient of a limited license may practice only with public agencies or institutions or nonprofit agencies or institutions meeting the requirements of §501(c)(3) of the Internal Revenue Code (a nonprofit, charitable, educational or scientific organization). Such agencies or institutions must be located in the areas of critical medical need as determined by the Board of Medicine. Holders of a limited license must keep current on their CME requirements. However, holders of a limited license are not required to maintain medical malpractice insurance.

While medical malpractice insurance is not required, it still may be in the physician's best interest to keep a policy in force. Holders of a limited license are subject to suits for malpractice in the same manner as those with regular licenses. Florida's Good Samaritan Act provides no additional protection. Limited license holders, however, who work for a state agency or subdivision or have contracted with the state to provide free care and treatment to indigent patients are statutorily afforded sovereign immunity protection. Having been vested with such protection, it is not necessary for these physicians to maintain medical malpractice insurance. It should be remembered, however, that such immunity only applies for acts or omissions of the physician while working within the scope of his employment with the state agency or subdivision or within the scope of duties pursuant to his contract with a governmental contractor.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: April 2013*

RETIRING/CLOSING/RELOCATING A PRACTICE

Section 456.057, Florida Statutes, sets forth the requirements that must be followed when a physician retires, closes his office or relocates his practice. The statute adopts the concept of a "records owner." A "records owner" may or may not be a physician. "A 'records owner' means any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous records owner; or any health care practitioner's employer, including, but not limited to, group practices and staff-model health maintenance organizations, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner." Section 456.057(1), Florida Statutes. The statute requires the "records owner" to notify patients of the retirement, closing or relocation of a practice. When the records owner retires, terminates a practice, or is no longer available to patients, Section 456.057(13), Florida Statutes, requires the records owner to notify the patients of the termination, relocation or unavailability in the following manner:

1. Publish in a local newspaper a notice containing the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician. This is now required by law per Florida Administrative Code 64B8-10.002(4). A copy of this notice must also be submitted to the Florida Board of Medicine.

2. Physicians may also, <u>but are not required to</u>, notify patients in writing of the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician) or place a sign in a conspicuous location on the façade of the physician's office.

3. Both notices must advise patients of their opportunity to obtain a copy of their records.

In addition, Section 456.057(14), Florida Statutes, requires that the records owner notify the Florida Board of Medicine and advise the Board who the new record owner is, and where the physician's medical records can be found. The records owner should also review all managed care contracts to determine if any notification provisions must be complied with.

This change will primarily affect employed physicians whose employment agreement designates the employer as the records owner. It will have little effect on other physicians, especially those physicians in independent practice. In that case, the physician who generated the record after treating the patient will be considered the "records owner," and therefore the requirements discussed above will fall upon that physician. In the case of an employed physician (whose employment agreement designates the employer as the records owner), this responsibility is placed upon the employer.

It is important to note that the Board of Medicine has adopted a rule that imposes certain requirements on physicians who relocate or terminate their practices and are no longer available to patients. Rule 64B8-10.002(4), Florida Administrative Code, requires physicians to publish a notice once a week for four consecutive weeks in a local newspaper of greatest circulation. The notice must contain the date of termination or relocation and include an address where the records may be obtained from the physician terminating practice or another licensed physician. A copy of the notice must be submitted to the Board within one month from the termination or relocation. The rule also gives physicians the option of <u>either</u> placing a sign in a conspicuous location in or on the façade of the physician's office <u>or</u> notifying patients by letter of the termination, sale or relocation of the practice (this is NOT required, however), <u>in addition to publishing the notice in</u>

the local newspaper. The sign or letter must notify patients of their opportunity to transfer or receive their records. The requirements set forth in the Board's rule are separate and apart from the requirements set forth in Section 456.057, Florida Statutes, and must be followed by all licensed physicians. Concomitantly, a physician is responsible for ensuring that these records will be available to his former patients for a period of five (5) years from their last visit. A physician thus must make arrangements to either have another physician become the new records owner, have a medical records service store copies of the medical records and provide copies upon request to former patients, or himself be available to provide copies.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: March 2013*

SCHOOL PHYSICALS

State law (Section 1003.22, Florida Statutes) provides that all Florida students need a **school entry exam** to attend school and that each county health department, with the approval of the school district, shall develop policy regarding initial school entry health examinations (Rule 64F-6.002, F.A.C.). Which type of physician must perform these exams is left up to each county/school district.

Florida law states that a "licensed practicing physician" must sign forms relating to: (a) medically related **immunization exemptions** (Section 1003.22(5)(b), Florida Statues); (b) **absences** due to sickness or injury (Section 1003.24(4), Florida Statutes); (c) attestations regarding the **age** of the student (Section 1003.21(4)(g), Florida Statutes). Since the statutes are silent regarding whether chiropractors fall into this definition of physician, many school districts require an MD or a DO to fill out these forms. The FMA successfully fought against changing the statutes to specifically allow chiropractors to perform these duties.

Florida law (Section 1003.22(5)(c), Florida Statutes) does allow a chiropractor, along with M.D.s and D.O.s, to certify that a student has received all required **immunizations**.

Florida law (Section 1002.20(17)(b), Florida Statutes) states that a student must have a medical evaluation before participating in **athletics**, but it does not state who may perform the exams. Therefore, each practice act must be examined to determine if it is within that scope of practice to perform the exam. General physical exams are within the scope of practice of an M.D., a D.O., an A.R.N.P. and a P.A. Other practice acts (such as 460 for Chiropractors) are not as clear.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

STATUTE OF LIMITATIONS FOR MEDICAL MALPRACTICE

Section 95.11(4)(b) of the Florida Statutes codifies the statute of limitations for medical malpractice claims. It provides in relevant part:

> "An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued, except that this 4-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday… The limitation of actions within this subsection shall be limited to the health care provider and persons in privity with the provider of health care. In those actions covered by this paragraph in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury the period of limitations is extended forward 2 years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed 7 years from the date the incident giving rise to the injury occurred, except that this 7-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday…"

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: April 2013

SUBPOENA COMPLIANCE

As most physicians are aware, patient records are confidential and cannot be released without the consent of the patient or the patient's legal representative. An exception to this general rule occurs, however, when a physician receives a subpoena requesting copies of a patient's medical records. If a physician receives a subpoena for patient records, the physician generally must honor the subpoena. According to Section 456.057(7)(a)3., Florida Statutes, patient information may be disclosed without written authorization from the patient "upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records." Failure to comply with a properly issued subpoena could result in the physician begin held in contempt of court and punished by a fine and/or imprisonment until such time as the physician complies with the subpoena. See Pedoroso v. State, 450 So.2d 902 (Fla. 3d DCA 1984).

It is important to note, however, that HIPAA does not allow a physician to comply with a subpoena for medical records unless the physician first receives satisfactory assurance that the person requesting the records has made a reasonable effort to notify the individual, who is the subject of the medical records that have been requested, of the request, or that reasonable efforts have been made to secure a qualified protective order. 45 CFR 164.512(e)(1).

Satisfactory assurance may be provided to the physician in the form of a written statement and accompanying documentation demonstrating that:

- The party requesting the medical record has made a good faith attempt to provide written notice to the patient;
- The notice includes sufficient information about the litigation proceeding in which the medical record is requested to allow the patient to raise an objection to the court or administrative tribunal; and
- The time for the patient to raise objections to the court or administrative tribunal has elapsed, and *either* no objections were filed by the patient *or* all objections filed by the patient have been resolved by the court or administrative tribunal and the disclosures being sought are consistent with such resolution.

A sample letter that a physician may send the attorney requesting the medical records is found in our forms section.

There are two instances in which a physician should not comply with a subpoena that is not accompanied by a court order. These instances involve records pertaining to physician's knowledge of a test result for the HIV virus, and second, when the records sought are substance abuse, psychiatric records, or records subject to the psychotherapist-patient privilege under Section 90.503, Florida Statutes.

There are two statutes under which psychiatric records may be confidential. Section 456.057, Florida Statutes, provides that communications between a patient and a psychiatrist are confidential. In order to be considered confidential, the communication must be by a physician "who has primarily diagnosed and treated mental and nervous disorders for a period of not less

than 3 years, inclusive of psychiatric residency." Section 456.057(8)(b), Florida Statutes. At the same time, Section 90.503, Florida Statutes, provides that communications or records "made for the purpose of diagnosis or treatment of the patient's mental or emotional condition" between the patient and the psychotherapist are generally confidential and may not be disclosed without the patient's consent. Under this statute, the three-year limitation contained in Section 456.057, Florida Statutes, does not apply. Under Section 90.503, a "psychotherapist" is defined to include any person authorized to practice medicine in the state "who is engaged in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction." It is important to note that this privilege is **not** absolute. The statutory privilege does not apply if a patient in a civil or criminal action relies on his or her mental or emotional condition as an element of his or her claim or defense. Section 90.503(4)(c), Florida Statutes. It is unclear whether the privilege afforded by Section 455.671 applies in the same situation.

In the event either of these two types of records are requested, the physician should contact the patient and request, if the patient does not object to release of the records, that the patient execute a specific, written release. If, however, the patient does not want the records to be released, the physician should notify the party who issued the subpoena that Florida law prohibits the release of these records without a specific court order. In these instances, the physician should not release the records until a specifically worded release from the patient or a court order is obtained.

A subpoena for deposition is only binding if properly served. Florida law makes no provision for service of subpoena by mail. Thus, the physician must be properly served with a subpoena before he can divulge patient confidences at deposition. Proper service requires that a copy of the subpoena be delivered to the physician or that a copy be left at that person's usual place of abode with any person residing therein who is 15 years of age or older informing the person of its contents.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

THINGS TO CONSIDER BEFORE SIGNING AN EMPLOYMENT CONTRACT

There are many things to consider before entering into an agreement with a potential employer. Below is a short and certainly not an exhaustive list of some of the most important considerations. Of all the items below, the first one on the list should always be adhered to.

1. Consult a qualified healthcare attorney to review any employment agreement before you sign it. Sure this will cost you money, but a careful review from an attorney experienced with physician employment issues can prevent legal problems down the road and may end up saving you far more money than what the review costs. An experienced attorney will be able to discuss with you all of the points below, as well as others you probably would never think of, and help you to negotiate the best possible deal.

2. Compensation. Make sure the compensation is appropriate, and clearly stated. A set annual salary is most common, and the least problematic from a legal standpoint. Beware of percentage based compensation arrangements as these can violate state and federal self-referral (Stark) laws and patient brokering laws. Be sure that all items of compensation are clearly set forth in the contract, such as vacation and sick leave, cell phone/iPad service, reimbursement for required continuing medical education, car allowance, 401K (will the employer match employee contributions?), and the amount and types of insurance provided (health, dental, life, disability, etc.). In addition, if your expectation is that after a period of time, you will be made an owner of the practice, the “how’s” and “when’s” should be clearly spelled out in the contract.

3. Malpractice Insurance. Who will pay for your malpractice insurance? While this is usually related to the amount of compensation you receive, it deserves special attention. Make sure your contract clearly spells out whether your employer has in place or will procure medical liability insurance that covers you specifically, and what the extent of that coverage is. If the employer is providing liability coverage, you need to deal with the issue of tail coverage should the employment terminate. Tail coverage can be quite expensive, and at the least, you should ask that the employer pay for the tail if the contract is terminated for any reason other than a breach by the employee.

4. Emergency Room Call Coverage. Make sure that the agreement sets forth whether you will be expected to provide emergency room coverage as part of your duties, and whether your salary covers the time spent on call, or whether you are entitled to overtime pay. If the hospital pays for call coverage, your contract should specify whether such monies go to the employer, or whether you are entitled to receive this pay.

5. Office Hours. Will you have established office hours? Similar to ER call, make sure you know what is expected of you. Will there be set days and times you are expected to be in the office, or will you have the flexibility to see patients on your own schedule?

6. Restrictive Covenants. Be aware of restrictive covenants. If at all possible remove these from your contract. Many physicians will sign an agreement with a restrictive covenant in the belief that such clauses are unenforceable. While many states have outlawed these types of agreements, in Florida, a restrictive covenant that is reasonable in both time and area is enforceable. Please see the article titled “Noncompetition Clauses.”

7. Ownership of Medical Records. Florida law provides that absent an agreement to the contrary, medical records are owned by the person who generates them. If you agree,

however, that your employer is the medical records owner for any records you generate, you will be stuck with that decision should you later wish to end the employment agreement. If you do agree that the employer is the records owner, you should insist that you be provided with full copies of all records that you generated should your employment terminate for any reason.

8. Stark Laws. Be aware of the Stark Law, 42 U.S.C. 1395nn. Hospital employment cannot be conditioned on referring patients, and incentive payments cannot vary based on the value or volume of referrals. The state and federal "Stark" laws are so complex that navigating its intricacies while negotiating your contract would be very difficult. Please refer back to item 1.

9. Outside Activities. Make sure that your contract states whether you will be allowed to engage in professional activities outside of your employment, such as providing expert witness testimony or speaking at medical seminars. If at all possible, make sure your contract states that you are entitled to keep the revenue generated from such engagements, at least for those done on your own time.

For an excellent analysis on this subject, please see the FMA's recent publication: "A Guide to Understanding and Negotiating a Physician Employment Contract From the Employee Perspective. This publication can be found on the FMA's website.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: May 2013*

UNLICENSED ACTIVITY

Section 456.065, Florida Statutes, is entitled "Unlicensed Practice of A Health Care Profession." It provides that "It is the intent of the Legislature that vigorous enforcement of licensure regulation for all health care professions is a state priority…"

A joint effort has been entered into between the Florida Department of Health and the Florida Attorney General's Office to combat unlicensed practice. Offices have been set up in Florida to investigate and assist in the prosecution of unlicensed activity in health care.

To report unlicensed activity, please call 1-877-425-8852 or visit www.doh.state.fl.us.

It is a felony to practice a health care profession without an active, valid Florida license. It is a higher degree felony, with higher penalties, if the practice results in serious bodily injury. The State Attorney's offices in Florida prosecute these cases as criminal matters; in addition, the health boards (such as the Board of Medicine) will take action against anyone practicing outside the law.

To ensure that your physician is duly licensed, visit the Department of Health's website at www.doh.state.fl.us

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns. *Last Update: August 2016*

VOLUNTEER IMMUNITY

For centuries the medical profession has been characterized by unselfish physicians who have donated their time and skill to provide care to those less fortunate. During the latter part of the 20th century, however, the rise of medical malpractice has made physicians wary of providing any care, much less gratuitous care, for fear of subjecting the physician to malpractice liability.

Fortunately, Florida has taken several actions to prevent the physician who responds to the needs of society's less fortunate through the provision of gratuitous care. As early as 1965, the state adopted a Good Samaritan Act (Section 768.13, Florida Statutes), which provided a small level of protection for physicians rendering emergency care to patients, regardless of whether the physician is compensated. The Good Samaritan Act provides immunity for any physician who renders care in an emergency situation without objection of the injured victim. In order to be entitled to the statute's protection, the physician must be able to demonstrate that he acted "as an ordinary reasonably prudent person would have acted under the same or similar circumstances." It is important to note that this statute provides immunity from liability only if the emergency care is provided "without objection of the injured victim." For example, if the victim objects to being moved, but the physician moves the victim anyway and provides emergency care, the physician will not be protected by this statute. Botte v. Pomeroy, 438 So.2d 544 (Fla. 4th DCA 1983), *review den.* 450 So.2d 488.

In 2003, the FMA endeavored to change the Good Samaritan Act so that it provided a real measure of protection for volunteer physicians. After extensive lobbying and five special sessions, the legislature added a section that provided immunity to health care providers providing emergency services pursuant to obligations imposed by EMTALA and comparable state legislation. The addition to the Good Samaritan Act provides that there is no liability for providing such medical care unless it was done under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another (Section 768.13 (b)1, Florida Statutes). This section provides a bit more protection from liability than the original above in that "reckless disregard" is defined as more than acting as an ordinary reasonably prudent person would have under the same or similar circumstances. For this addition "reckless disregard" is defined as "such conduct that a health care provider knew or should have known, at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater that that which is necessary to make the conduct negligent." Section 768.13 (b)3, Florida Statutes (emphasis added).

Over the years, the state has provided further incentives for physicians to provide services to the poor and on behalf of the state. In 1992, Section 766.1115, Florida Statutes, was enacted to provide sovereign immunity to those physicians and §501(c) organizations which deliver health care services on a volunteer basis. As a result, physicians and nonprofit entities under which they provide their services may not be held liable for more than $100,000 per patient as a result of any medical malpractice.

Unfortunately, this law did not provide sufficient protection to the individual physician who desired to provide volunteer services under the umbrella of the state or a nonprofit agency. For this reason, the state responded in 1993 by passing the Volunteer Protection Act (Section 768.1355, Florida Statutes), which stated that any person performing volunteer services for any nonprofit organization or any governmental entity would "incur no civil liability for any act or omission by such person which results in personal injury" as long as the person acted in good faith and "as an ordinary reasonably prudent person would have acted under the same or similar circumstances." In addition, the injury must "not [be] caused by any wanton or willful misconduct on the part of such person in the performance of such duties."

During that same legislative session, the state passed the Professional Malpractice Immunity Act Section 768.1345, Florida Statutes), which explicitly stated that "[n]o person shall have a claim for professional malpractice against a licensed professional who provides services for which no compensation is sought or received to such person during the period of a declared emergency if the professional services arose out of the emergency and if the professional acted as an ordinary, reasonably prudent member of the profession would have acted under the same or similar circumstances."

As a result of these actions, physicians who wish to volunteer their services within the State of Florida have received substantial, although incomplete, liability protection for volunteer services rendered in good faith. To receive the maximum protection, however, physicians must, in all but emergency circumstances, provide their services through a recognized nonprofit agency or the state. Only in this way may physicians help others without the fear of hurting themselves.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.
Last Update: October 2005

WORKERS' COMPENSATION: CERTIFIED HEALTH CARE PROVIDER

As a condition to eligibility for payment under Chapter 440, Florida Statutes, Workers' Compensation, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This requirement does not apply to emergency care. The Agency for Health Care Administration (AHCA) adopts rules to implement the certification of health care providers.

A "certified health care provider" means a health care provider who has been certified by AHCA or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers. Certification of health care providers must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance. Physicians licensed under Chapter 458, an osteopathic physician licensed under Chapter 459, a chiropractic physician licensed under Chapter 460, a podiatric physician licensed under Chapter 461, an optometrist licensed under Chapter 463, or a dentist licensed under Chapter 466, must be certified by AHCA prior to seeing injured employees insured under Florida workers' compensation laws.

Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under Chapter 440, Florida Statutes. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in the chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by Chapter 440. Providers have recourse against the employer or carrier for payment for services rendered in accordance with the chapter. Payment to health care providers or physicians shall be subject to the medical fee schedule and applicable practice parameters and protocols, as outlined in Chapter 440.

A health care provider may not refer an injured employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is being rendered. Any workers' compensation patient referral must be to a health care provider that has been certified by AHCA, unless the referral is for emergency treatment. The referral must be made in accordance with practice parameters and protocols of treatment as provided for in Chapter 440.

Certification information and an application can be found at the following link:

http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/WCMC/docs/WC-Intro-WCMHC.shtml

To determine if a health care provider is certified, go to the following link:

http://www.fdhc.state.fl.us/workers_comp/owa/workers_comp.providers.wc_index

---

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

WORKERS' COMPENSATION & THE PHYSICIAN BUSINESSMAN

Today's physician faces numerous risks when establishing a practice. One of these risks is that of employees becoming hurt on the job, as Florida law states the employer must pay not only the medical expenses of the injured employee, but also a significant portion of the wages the employee would have earned had the injury not occurred. This expense, coupled with the need to hire a replacement, often is devastating to a practice. It is for this reason that many physicians voluntarily insure their practice by obtaining Workers' Compensation coverage. For others, however, the expense of such coverage is not justified by what is perceived to be the slight risk of liability. Therefore, every medical practice must evaluate its individual Workers' Compensation needs.

For many practices, the choice of how to insure against workplace injuries is limited by Florida law. If the practice has four or more employees, the employer <u>must</u> secure coverage either by obtaining a policy through a commercial insurance carrier or by providing satisfactory evidence of the physician's ability to self-insure with the Division of Workers' Compensation. In determining whether a specific business has more than three employees, it should be noted that the definition of employee does not include independent contractors, and corporate officers may exclude themselves from the definition should they wish. For example, a professional association in which a sole physician (president of the PA) employs three office staff would not be required to obtain Workers' Compensation coverage if the president excludes himself from the definition of employee, as the office would maintain only three employees and not be subject to mandatory insurance. On the other hand, a similar physician employing four office staff members would be required to obtain coverage. Should an employer wish to self-insure, the Division of Workers' Compensation may require the employer to post a bond or other security to ensure the employer's ability to make any necessary payments, should the need arise.

Assuming the physician has a choice of whether to obtain insurance, the costs of such insurance must be balanced against the likelihood and significance of any potential claim. If the business obtains coverage from a commercial carrier, it will incur regular billings at a set amount, but will incur no additional liability in the event of the workplace injury. Should the business wish to self-insure, the state may require that a specific amount of assets be placed into an escrow account to cover any future claims. Even this amount, however, may not be sufficient to cover the financial obligations of the business. For instance, if an employee physician earning $104,000 per year were to become disabled, the professional association would be required to pay not only the medical expenses of the employee, but also $1,333.34 per week for 700 weeks, resulting in a total payment of $933,338.00, not including medical expenses.

In the event an eligible employer were to opt out of Workers' Compensation completely (which requires the submission of an affidavit to the Division of Workers' Compensation), the cost of such an employee injury would significantly increase. Under current Worker's Compensation law, an employer covered by Worker's Compensation either through a commercial carrier or through self-insurance may not be sued at common law. As a result, the employer is not liable for the full amount of damages, but only medical costs and 2/3 of the weekly earnings, and may not be sued for punitive damages. By contrast, if the employer above had elected not to be covered by

Worker's Compensation, he would be required to pay $1.4 million in damages for lost wages, in addition to being liable for punitive damages and medical expenses.

For the above reasons, even small practices should seriously consider obtaining commercially funded Workers' Compensation insurance. Although the cost may be significant, it may be mitigated by the adoption of a drug-free workplace program, and recent revisions to the Workers' Compensation law have significantly reduced the annual increases in such fees. More importantly, however, such policies can protect the physician's practice from astronomical liability which would make most malpractice judgments pale in comparison.

This article is presented for educational purposes only and should not be taken as a substitute for legal advice, which should be obtained from personal legal counsel. Nevertheless, the FMA hopes that the information provided here and in its other publications continues to assist physicians in answering many of their most common legal questions allowing them to treat patients, instead of addressing legal concerns.

Last Update: October 2005

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ___________________ (name of patient) hereby authorize ___________________ (name of physician) to (check all that apply):

- ❑ use the following protected health information in a manner not inconsistent with this authorization, and/or
- ❑ disclose the following protected health information in a manner not inconsistent with this authorization to ____.

This authorization is for the use and/or disclosure of the following protected health information (describe in detail the type of protected health information being used or disclosed):

____
____
____
____
____.

This protected health information is being used and/or disclosed for the purpose of:

____
____
____
____

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited. An additional written authorization must be completed for any proposed new use or disclosure of the protected health information to another person or entity or for any other purpose.

This authorization shall remain in effect until _____________________, 20__.

I understand that I may revoke this authorization in writing, provided, however, that I may **not** revoke this authorization to the extent that _______________________ (name of physician) has acted in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and other law gives the insurer the right to contest the claim or the policy itself.

I may revoke this authorization by mailing a written statement revoking this authorization by certified mail to __________________________(name of physician) at the following address:

____, Florida 323___

I further understand that ____________________ (name of physician) may not condition the provision to me of treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide an authorization, except that (1) my physician may condition the provision of research-related treatment on my providing a authorization for the use or disclosure of protected health information for such research and (2) my physician may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my providing a authorization for the disclosure of the protected health information to the third party.

I understand that the protected health information disclosed pursuant to this authorization may not be protected by federal law once it is disclosed by my physician.

____
Name of patient or personal representative signing this authorization

____
Signature of patient or personal representative signing this authorization

Date:________________________, 20___

If signed by personal representative of patient, please indicate relationship:

- ❑ Parent or guardian of minor (if minor could not have authorized care)
- ❑ Guardian of an incompetent patient
- ❑ Personal representative of deceased patient
- ❑ Court-appointed representative

PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE IS ENTITLED TO A COPY OF THIS AUTHORIZATION.

CONSENT TO TREATMENT

Date:____________________Time_______(a.m./p.m.)

I have been advised by Dr. ______________________ of the nature, possible alternative methods of treatment, and the possible consequences and complications involved in the treatment of __________ __ ____through the use of ____.

Nevertheless, I authorize Dr. ______________________ to administer such treatment to me.

Signed: ____________________________ Witness: ____________________________

Address: ____________________________

____

HEALTH CARE ARBITRATION AGREEMENT

ARTICLE 1: General Provisions

The patient agrees that any controversy, including any malpractice claim, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned physician, including any partners, agents, or employees of the physician, shall be submitted to binding arbitration.

The patient further agrees that any controversy arising out of or in any way relating to the **past** diagnosis, treatment, or care of the patient by a provider or medical services, or the provider's agents or employees, shall likewise be submitted to binding arbitration.

INITIAL:________

Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

ARTICLE 2: All Claims Must Be Arbitrated

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

ARTICLE 3: Procedures

Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes s. 682.01 et. seq.

In the event that any party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of the arbitration agreement, or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite its absence at the arbitration hearing.

ARTICLE 4: Patient's Right to Cancel Arbitration Agreement

The patient has the right to rescind this agreement by written notice to the provider of medical services within _____ days after the agreement has been signed and executed. The patient may rescind by merely writing "cancelled" on the face of one of his copies of the agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such copy to the provider of medical services with such _____ day period.

ARTICLE 5: Arbitration as Exclusive Remedy

With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrators.

ARTICLE 6: Death of Party not to Affect Submission

This submission shall not be withdrawn or affected by the death of either of the parties pending a final award, but the executor, administrator, or other representative of the party shall be deemed to be a party to this submission made, any rule of law or equity to the contrary notwithstanding. The parties agree that this agreement is to be binding on the parties' assigns, heirs, executors, and administrators.

ARTICLE 7: Acknowledgements

The patient, by signing this agreement, also acknowledges that he or she has been informed that:

(1) Medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;
(2) The agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;
(3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital;
(4) The patient must be furnished with two copies of this agreement.

ARTICLE 8: Awardable Damages

The damages awardable at arbitration are limited to those available under Florida law.

BY SIGNING THIS CONTRACT YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

_______________, 20___ By____
Physician

_______________, 20___ By____
Patient

_______________, 20___ By____
Parent or Guardian if patient is a minor

HIV AND AIDS INFORMED CONSENT FORM

Date: ________________________ Time:___________a.m/p.m.

I, ________________, hereby acknowledge that Dr. ____________________ has explained to me a Human Immunodeficiency Virus (HIV) or AIDS test, its purpose, potential uses, limitations and the meaning of its results. I further acknowledge that I have been advised that a positive test result will be reported to the county health department with sufficient information to identify me, and on the availability and location of sites at which anonymous testing is performed.

I hereby authorize and consent to the taking of blood from me for the purpose of conducting an HIV test. I understand that a second or confirmatory test may be necessary before any test results are released (whether positive or negative); provided, however, that preliminary test results may be released to me and to health care providers when decisions about medical care or treatment for me cannot await the results of confirmatory testing.

Signed:_______________________________________

Patient or person authorized to consent for patient

Witness:_____________________________________

LETTER FROM PHYSICIAN TO ATTORNEY WHO HAS SUBPOENAED MEDICAL RECORDS

Re:

Dear :

On __(date)__ ___(name of physician)___ received a subpoena from you requesting the medical records of __(name of patient)__. __(Name of Physician)__ is prohibited from complying with your subpoena requesting production of this patient's medical records because your subpoena does not comply with the requirements for subpoenas set forth in 45 CFR 164.512(e)(1)(iii) of the Health Insurance Portability and Accountability Act (HIPAA).

As you know, HIPAA does not allow a physician to comply with a subpoena for medical records unless the physician first receives satisfactory assurance that you have made reasonable efforts to notify the individual, who is the subject of the medical records that have been requested, of the request, or that reasonable efforts have been made to secure a qualified protective order.

Satisfactory assurance may be provided to ___(name of physician)___ in the form of a written statement and accompanying documentation demonstrating that:

- The party requesting the medical record has made a good faith attempt to provide written notice to the patient;
- The notice includes sufficient information about the litigation proceeding in which the medical record is requested to allow the patient to raise an objection to the court or administrative tribunal; and
- The time for the patient to raise objections to the court or administrative tribunal has elapsed, and *either* no objections were filed by the patient *or* all objections filed by the patient have been resolved by the court or administrative tribunal and the disclosures being sought are consistent with such resolution.

Once we receive the required information, we will prepare the medical record in response to your subpoena.

If you have any questions regarding this matter, you may contact me at ___________(telephone number).

Sincerely,