

# FSIPP NEWSLETTER

SPRING, 2008

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EDITOR-IN-CHIEF: DEBORAH H. TRACY, MD

## *President's Message Greetings to All*

**Lora Brown, MD**



FSIPP officers have been diligent in fighting the Medicare RAC's attack on Florida's pain management community. For those of you unfamiliar, RAC's (Recovery Auditor Contractor) are composed of contracted auditing companies hired by Medicare to recover monies thought to be over or under paid to physicians. These contractors receive about one third of what they recover either from the physician or Medicare. Their only motivation is **MONEY** and they are incentivized to stretch the interpretation of Medicare guidelines. As a result of the work of FSIPP with the support of the FMA, CMS has notified the Florida Medicare RAC (HDI) to Cease and Desist its recent audit of cases performed without fluoroscopy, involving hundreds of Florida Physicians. Please see our summary article in this edition of the FSIPP Newsletter.

As the seasons change and spring arrives, we are now only three months away from the ASIPP 10th Annual Meeting Celebration and Washington DC Lobby, scheduled for June 21-25, 2008. This annual Meeting will feature Practice Management for Interventional Pain Physicians and Professional Legislative Sessions with Capitol Hill Visits. There will be a Saturday night black tie gala to commemorate the occasion, to be hosted at the Marriot Crystal Gateway in Washington DC. Please see the ASIPP brochure at [asipp.org](http://asipp.org).

For those of you who have not attended in previous years, this is a wonderful opportunity to learn about legislative issues affecting you and your practice, meet lawmakers, and become a part of effective change. I encourage everyone to take a few days out of your busy schedules to attend this paramount event.

On August 1, 2, 3, 2008, the combined FAPM/FSIPP annual meeting at the Gaylord Palms in Orlando should be a great meeting, fantastic for networking. Our pre-conference workshop will focus on issues we are all struggling with including: audits, compliance, partnership agreements, practice financial analysis, local coverage determinations (LCDs) and staying out of trouble.

In addition to the educational format, FSIPP will be holding its annual officers and general membership meeting during the FAPM conference. We will be electing new officers at that time. I would like to remind everyone that we are seeking nominations for board positions by email. Please do not hesitate to get involved. This organization is only as strong as its members and officers.

**Pain management in the State of Florida needs YOU to take an active role!!!!**



### *Inside this issue:*

**RAC Audits**

**Historical Overview of IDET**

**Changes in Medicare, LCDs**

**FSIPP Annual Meeting (with FAPM) and elec-**

**FDA Warning: Methadone Hydrochloride Tablets**

**Vaughn Reading Room**

**FPIC Legal FAQs**



## *RAC Audits Here To Stay*

The Medicare Recovery Audit Contractor (RAC) pilot programs in Florida, California, and New York, ended on February 1, 2008. Congress, however, has approved expansion of the RAC effort to all 50 states by January 2010. Since Florida was a pilot state, Health Data Insights (HDI) will likely win the contract for the Southeastern United States Region and take very little time restarting the Florida audit effort. The contractors have shown they're pretty good at their work. In just three years, they've returned more than \$300 million to the federal government and that's just from three states. That experiment is winding down. But a larger, national program will soon take its place. The rollout of "recovery audit contractors" will be gradual. They'll monitor health care providers in 19 states beginning this spring. In October, an additional five states will join.

As you will recall, there are three types of Medicare contracted "carriers" who address your claims: (1) your regular contractor to whom you submit your claims; (2) a Program Safeguard Contractor ("PSC") whose purpose is to investigate potential fraud; and (3) RAC's, who are paid on a contingency basis, i.e., they keep one-third of whatever they recover from a targeted provider. In the Florida audits, a RAC known as Health Data Insights ("HDI") has initiated these audits. Under the Medicare Modernization Act of 2003, RAC's not only recover their contingency fee for what was overpaid, but also for what was underpaid.

HDI recently initiated an extensive audit which involved the use of fluoroscopic guidance for certain interventional pain procedures. If a procedure requiring fluoroscopy was performed without fluoroscopy being paid, that file was targeted for repayment of the procedure and any drugs administered therewith. Providers were audited even if they used fluoroscopy, but were not paid by the Medicare carrier (First Coast Service Options, in Florida). In essence, there were two types of audited claims for fluoroscopy: (1) those which did not submit a charge for fluoroscopy when an interventional procedure was performed, and (2) those which did, but were not paid.

The nature of these audits was unusual. The RAC used as its authority that various interventional procedures require fluoroscopy, an excerpt from a Federal Register "FR" (68 FR Part 60, p. 15267), publication dated March 28, 2003, entitled, "Update of Ambulatory Surgical Center List of Covered Procedures Effective July 1, 2003," and in which there was a comment that CMS had previously proposed to delete a whole host of procedures from the covered ASC list of procedures, but changed its mind after pain management physicians argued that these procedures were of a type that should be done in an ASC, in part, because "fluoroscopic guidance is necessary to assure precise needle placement." The procedures included those represented by CPT codes 64410, 64415, 64417, 64420, 64421, 64430, 64442, 64443, 64510, 64520, 64530, 64600, 64605, 64610, 64620, 64622, 74723, 64630, and 64680.

An argument by pain physicians, who were lobbying to keep procedures on the approved ASC list, is not equivalent to a ruling by CMS. These were pain physician arguments, not CMS comments. The only procedure in the CPT Code requiring fluoroscopy for proper billing at the time was an SI joint injection. Florida Medicare (First Coast) recently adopted a facet LCD (LCD L6146) that includes a fluoroscopic limitation when billing facet blocks, stating, "Blocks performed without the use of fluoroscopy are considered not medically necessary." This language was added on 8/31/07, with an effective date of 9/30/07, and should not be applied retroactively. Fluoroscopic guidance will also be required for Epidural Steroid Injections when used for chronic pain. The CMS is currently working on a list of all interventional procedures that will require or mandate the use of fluoroscopic guidance.

For the immediate future, you should get no new demand letters. Any issues identified prior to February 1, 2008, will continue to be processed. As a note of warning, physicians who receive requests for information or demand for overpayments from HDI must make a timely response, or Medicare will assume the overpayment demand to be valid and deduct those monies from your current Medicare reimbursements. If you are notified by the RAC demanding a refund, please respond to them promptly. Failure to do so will seriously impede your appellate options. First Coast will send you a formal demand letter with your appeal rights, which you should exercise. You have 120 days from the date of the First Coast Service Options demand letter to appeal. The first level of appeal is called a "Redetermination," and CMS has Redetermination forms on its web site. The second level of appeal is called "Reconsideration" to a different contracted appeal carrier, and again, CMS has Reconsideration forms on its web site.

The clinical staff at FCSO has supported the unfairness of this audit. We understand that Attorney Fred Whitson of

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the FMA has received communication that CMS has notified HDI to Cease and Desist in its attempts to collect on the basis of no fluoroscopy, but we have seen nothing in writing. We believe that the audit could still continue with efforts focusing on medical necessity and documentation. CMS has taken no formal position in writing or on the CMS Website.

**FOR ASSISTANCE WITH AUDITS FSIPP RECOMMENDS:**

1. FMA, CALL **850 224-6496**  
or [lbarber@medone.org](mailto:lbarber@medone.org).
2. ATTORNEY DAVID VAUGHN, VAUGHN & ASSOCIATES, LLC  
**Tel: 225-769-1320**  
[david@lalawfirm.net](mailto:david@lalawfirm.net)



### *Historical Overview Of Idet*

Rinoo Shah, MD

The intervertebral disc is a remarkable structure that resides in our bodies. It is found throughout mammalian species. Even as we transitioned from quadrupeds to bipeds, two million years ago, the disc stuck with us. It allows tremendous flexibility and yet it can withstand tremendous forces in all planes. Sadly, it leads a doomed existence and will fail 35 to 55 years after birth. Pejoratively, this is known as disc degeneration and euphemistically, as age-appropriate changes of the spine. This is not a problem, since the disc is uniquely adapted to serve the hunter-gatherer with a life expectancy of 40-50 years. It is a problem, however, for modern humans.

Advances in health care have doubled our life expectancies. However, the advent of a modern industrial society has eroded the potential for an early retirement. The fragmentation and diminishing size of families limits getting physical assistance from our kin or social networks. Consequently, one cannot simply take a break from chronic back pain. Disc degeneration and chronic back pain hit adults during their peak earning and productive years. Longer work hours, unpredictable workflows, smoking, chronic illness, obesity, stress, and genetics have contributed to a back pain epidemic. Back pain patients vary in age, demographics, sex, race, and socioeconomic status. In summary, the development of back pain and the consequent disability in a large segment of the population does not surprise me—it is a predictable consequence of many factors.

Despite the heterogeneity of patients with back pain, investigators believe the failing intervertebral disc is a common cause for disabling back pain. Degeneration of the disc has been linked to back pain. The concept that a small tear inside the disc—internal disc disruption—could cause severe pain, is a recent development. This theoretical construct led to the growth in spinal fusion surgery and conservative treatments, focused on the disc.

Unfortunately, the chasm between conservative care and spinal fusion is huge. Many patients are nervous about making this leap, despite their suffering. Although spinal fusion helps some patients, there are inherent surgical risks and there is a failure rate. Surgical failures are termed 'failed back surgery syndrome' or 'post laminectomy syndrome'. More precisely, this is the failure of the surgery to meet the expectations of the patient or surgeon. This population is difficult and costly to manage. Many of these patients will require narcotics and many will not return to work. They suffer in silence, often at the margins of society. As a pain physician, I see many of these patients. Despite these shortcomings, spinal fusion technology and growth have exploded over the past 30 years.

Patients and physicians, however, seek out less invasive options. The IDET procedure represents a major advancement in the ability to offer a minimally invasive treatment to patients with chronic back pain. IDET has been effective in bridging the chasm between conservative care and spinal fusion surgery. It has a good safety profile and has a large body of evidence supporting its utility in well selected patients.

The Intradiscal Electrothermal Therapy procedure has been around for about 10 years and has treated about 75,000 patients. Roughly, this is 7,500 patients per year. This is a small number, in comparison to the 250,000 spinal fusions performed annually. Furthermore, an IDET costs 10-15% of a spinal fusion. Hence, the overall utilization of the IDET procedure in relation to the prevalence of back pain is very small when compared to spinal fusion, chiropractic care, physical therapy, or medication management.

IDET is a minimally invasive technique to treat back pain. It is a technique based on established mechanisms of back pain. I have performed it on numerous patients with outcomes consistent with the reported literature. Patients meet

(Continued on page 4)

(Continued from page 3)

specified selection criteria. The physician is obligated to perform a comprehensive diagnostic evaluation. I perform this technique in patients with whom I have established a longitudinal doctor-patient relationship. If the procedure succeeds or fail, I try to maintain a therapeutic alliance to monitor their pain and functional status. In other words, I do not summarily end my physician obligations when the procedure finishes.

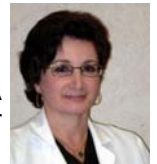
Even if 10% of patients benefit and can be spared spinal fusion, this would lead to a savings of approximately 50,000x750=\$25 million/year. If 50% of patients benefit, the cost savings would be \$250 million/year. This is based on current rates of utilization. Additional benefits may be achieved as more patients gain access to this treatment. Other cost savings may be realized by the reduced use of analgesics or the reduced incidence of failed back surgery syndrome.

Appropriately trained physicians should have the capacity to offer this treatment to selected patients with chronic low back pain. The IDET has the potential to improve pain, quality of life, functional status, and health care utilization among patients with chronic low back pain. I support a National Coverage Determination for the IDET procedure.

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### *Medicare And The ABCs For Your Patients*

Deborah H Tracy MD, MBA  
Editor-in-Chief, FSIPP Newsletter



Medicare is the largest health care program in the United States, covering 42 million Americans. It covers major medical expenses, such as hospital stays and doctor visits but does not cover routine eye care, dental care and long term care expenses.

The system is multipart. Part A covers hospital and skilled-nursing facility and Part B covers doctor visits, home health and laboratory tests. In 2006, Medicare offered Part D which is a prescription drug benefit for an extra premium. For all Parts the patient is responsible for deductibles, copayments and coinsurance payments. Part C plans are managed-care and generally limit participants to certain doctors and hospitals. These plans may cover some expenses that regular Medicare does not and they may include a prescription drug benefit. Patients can sign up for Medicare about 3 months before their 65<sup>th</sup> birthday and must sign up separately for Part D. If they are receiving Social Security Benefits they are automatically signed up for Medicare.

A Medigap insurance policy is health insurance that is sold by private insurance companies that fills "gaps" in the Original Medicare Plan. These plans can vary in cost, the more coverage the higher the premium, but commonly cover deductibles, copayments and coinsurance payments. Patients should apply for Medigap within 6 months of enrolling in Part B. During this 6 month period patients cannot be rejected because of a preexisting medical condition. Standard benefits of a Medigap plan for Part A, hospitalization, includes payments of coinsurance plus coverage for 365 additional days during a patient's lifetime after Medicare benefits have been exhausted. It also pays Part B coinsurance which is generally 20%. Some plans have additional benefits such as prescription drug coverage, home health, skilled nursing and deductibles for both Part A and B. If a patient is enrolled in Part D they cannot have a Medigap drug coverage policy.

Medicare Part D program is run through private companies, but has basic standards. In 2006 the average monthly premium more or less was \$32.20. The annual deductible was \$250, after a patient reached this deductible they usually paid 25% of a drug expense up to \$2,250. They paid 100% of the cost above \$2,250 until they reached \$3,600 in out of pocket expenses. Then they paid 5% of prescription drug costs or a copayment of \$2 for generic and \$5 for brand-name drugs. Medicare Part D cannot turn down a patient because of income or health history. Generally the enrollment period is three months before a patient turns 65 to three months after. After the initial eligibility period a patient can only enroll from November 15<sup>th</sup> through December 31<sup>st</sup> each year.

It is estimated that in 2003, Americans paid an average of \$3,757 in out-of-pocket health care expenses according to estimates from the Urban Institute. According to the Employee Benefit Research Institute an individual who retires at age 65 and lives to age 80 will need as much as \$137,000 for health care expenses in retirement; this assumes a rise in health care expenses of 7% per year. The Centers for Medicare & Medicaid Services offer free publications to help patients understand their health care options and learn about coverage. Patients can get copies online at [www.medicare.gov](http://www.medicare.gov) or by calling 800 633-4227.

## Changes In Medicare, LCDs

FSIPP has appointed representatives to the Medicare Carrier Advisory Committee. As members of this Medicare Committee FSIPP is able to educate Medicare and Committee members on issues relating to interventional pain procedures. We feel that this representation been successful in affecting Carrier decisions relating to pain procedures. Although we don't always achieve everything we ask for, there is usually a compromise that is acceptable.

Over the past several months there have been changes, additions and clarification to several LCDs (Local Coverage Determinations):

### 1. LCD, Viscosupplementation Therapy for the Knee (L1600). Effective 01/01/2008. [Click here for the direct link to view this LCD on the Medicare Website is:](#)

#### Summary:

1. A patient must fail conservative therapy for 3 months, this must be documented and include NSAIDS and Corti-  
sone Injection.
2. X ray must be on file, anywhere.
3. A series is defined as 3 to 5 injections depending on what product you are injecting and expected to be given at  
1 week intervals.
4. A patient may not receive a second series within 6 months of the last series.
5. There is no lifetime limitation.
6. Fluoroscopy imaging is **not** routinely covered, but may be if there is adequate documentation.

Medication:Supartz  
Weekly Dosage/Injections per week :25 mg/1  
Total Dosage:125 mg  
Duration of Treatment:5 weeks/single course of treatment per knee

Medication:Synvisc/Hyalan G F  
Weekly Dosage/Injections per week :16 mg/1  
Total Dosage:48 mg  
Duration of Treatment:3 weeks/single course of treatment per knee

Medication:Hyalgan  
Weekly Dosage/Injections per week :20 mg/1  
Total Dosage:100 mg  
Duration of Treatment: 5 weeks/single course of treatment per knee

Medication:Orthovisc  
Weekly Dosage/Injections per week :30 mg/1  
Total Dosage:90-120mg  
Duration of Treatment:3-4 weeks/single course of treatment per knee

Medication:Euflexxa  
Weekly Dosage/Injections per week :20mg/1  
Total Dosage:60 mg  
Duration of Treatment:3 weeks/single course of treatment per knee

### 2. LCD Epidural (L6443)

Effective 02/29/2008. [Click here for the direct link to view this LCD on the Medicare Website](#)

#### Summary:

1. Epidurals for chronic pain should be performed under fluoroscopic or DT-guided imaging
2. Epidurals combined with other blocks on the same day are not considered medically  
necessary.
3. Diagnostic Epidural should be limited to 2 injections.
4. During treatment a series of 3 injections may be given at a minimum of 2 weeks.
5. A series of 3 injections may be repeated at 6 month intervals.

### 3. LCD Paravertebral Facet Joint Blocks (L6146)

Effective 02/29/2008. [Click here for the direct link to view this LCD on the Medicare Website](#)

(Continued on page 6)

*(Continued from page 5)***Summary:**

1. Should be performed using direct visualization with fluoroscopy.
2. Procedures should be limited to 3 levels whether unilateral or bilateral.
3. No repeat treatment in less than 90 days at the same anatomical level.
4. No other procedures are appropriate during the same session except SI Joint injection.



***FSIPP Annual Meeting  
In Conjunction With FAPM  
August 1, 2, 3, 2008  
Gaylord Palms, Orlando***



This year's FSIPP Annual Meeting will again be held at the fantastic Gaylord Palms in Orlando and coordinated with the Florida Academy of Pain Medicine. We have an exciting agenda that will be finalized and published in the next month. This is an election year and as such there will be elections of officers at the annual meeting.

**Nominations for Officers / Directors at Large, FSIPP Meeting August 2, 2008**

As per the Bylaws, the Board of Directors serves as the nominating committee for the FSIPP organization. Following positions are OPEN: President-Elect, Vice President, Secretary, Treasurer, and Director-at-Large seats 3, 4, and 5. The Board unanimously nominated those with an asterisk, and additional candidates have self-nominated. The FSIPP Board is interested in new people! Please, if you are interested in serving, or you want to nominate someone else to serve, contact Lorry Davis, Executive Director ([director@fsipp.org](mailto:director@fsipp.org)). There will also be nominations taken from the floor at the time of the elections.

1. President 2008-2010 – Harold Cordner, MD
2. Past President – Lora Brown, MD
3. \*Elect – Deborah Tracy MD
4. \*President – Sandy Silverman MD
5. \*– Charles Grudem MD
6. \*– Jonathan Daitch MD

**Directors-at-Large**

1. Rafael Miguel, MD (2006)
2. Marshall Bedder, MD (2007)
3. \*Jesse Lipnick MD (2008)
4. \*Osman Latif DO (2008)
5. \*James Worden MD (2008)

**Additional Candidates for Open Director-at-Large Seats:**

Demetrios Kiaifas MD  
Harold Dalton DO

***Methadone Hydrochloride Tablets USP 40 mg (Dispersible)***

As of January 1, 2008, manufacturers of methadone hydrochloride tablets 40 mg (dispersible) have voluntarily agreed to restrict distribution of this formulation to only those facilities authorized for detoxification and maintenance treatment of opioid addiction, and hospitals. Manufacturers will instruct their wholesale distributors to discontinue supplying this formulation to any facility not meeting the above criteria.

Methadone is a long-lasting opioid medication used in the treatment of pain and narcotic addiction. The 5mg and 10 mg formulations indicated for the treatment of pain will continue to be available to all authorized registrants, including retail pharmacies. The 40 mg methadone formulation is indicated for the detoxification and maintenance treatment of opioid addiction. The 40 mg strength is not FDA approved for use in the management of pain. Thus, the distribution and availability of the 40 mg formulation will be limited to registrants in only those settings using the 40 mg formulation for the appropriate indication. The DEA and pharmaceutical industry agree that the reported increase in methadone-related adverse events merits action and further agree to a united effort to assure that methadone is properly distributed, consistent with its approved uses. Industry and the federal entities involved commit to monitor the progress of this initiative.

*FDA warning letter on methadone, issued 11/28/06.*

## Reading Room

### *Battling Payers' Bundling of Fluoroscopy*

3/25/2008



VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

Many payers are trying to bundle fluoroscopy into payment for chronic pain injections. Recently, this bundling attempt has increased due to the numbering change from old fluoro code 76005 to new fluoro code 77003. Although the descriptor language is identical between the two codes, the change to a new number caused payers to actually read the CPT Code's introductory comments to the Spine and Spinal Cord section, in which the CPT Code states, "Injection of contrast during fluoroscopic guidance and localization is an inclusive component of [the spinal injection codes]." Payers latched onto the phrase that injection of contrast is an inclusive component, i.e., bundled. However, the CPT Code's introductory comments do not state that fluoroscopy itself is an inclusive component, only that an injection of contrast is bundled. By way of history, and some of you may remember this, the language stating that an injection of contrast is bundled stems from pre-2000 when some pain providers billed the old epidural code twice, once for the injection of contrast into the epidural space and once for the injection of steroid into the epidural space, thus double dipping. To curb this, the introductory language was amended in the Spine and Spinal Cord section to make it clear that the initial injection of contrast is part of the payment for the epidural (or any other nerve block), but that has nothing to do with bundling the radiographic localization of the needle. So, while two surgical codes are bundled (i.e., contrast and steroid injections), the radiographic service of localizing the needle is not bundled. For those of you needing documentation to send to your payers, the ASA's Committee on Economics published a paper last year which discusses this in detail, and could prove useful in sending to your payers to help explain that fluoroscopy is not bundled, and should not be confused with the injection of contrast, which is bundled. See the attached ASA Memorandum.

VAUGHN & ASSOCIATES, L.L.C.  
Lawyers for Healthcare Providers

### *50 Modifier Deleted by CMS for ASC Facility Fee Billing*

Thursday, January 17, 2008

Effective January 1, 2008, CMS deleted the 50 modifier (bilateral procedures) for ASC's billing their facility fees. This does not affect the physician's professional fee billing when performing a bilateral procedure in the ASC (i.e., you still bill the 50 modifier on the professional fee side using the CMS 1500 form); it only affects the ASC's facility fee billing.

If you own as ASC, you have the choice of billing the left side on one line item with 1 in the units field, and the right side on another line item with 1 in the units field, with neither procedure receiving a modifier; or, alternatively, you can bill only one line item for the left and right sides with 2 in the units field. The 50% multiple procedure reduction will be applied to the bilateral side. The source document is MLN Matters Number: SE0742 on the Medicare Learning Network, pp 10-11.

## *Legal FAQs From*



*For information specific to your state of practice, contact FPIC's Risk Management Department*

***Does HIPAA privacy law or Florida statutes require a physician to obtain the patient's written authorization in order to transfer their medical records at the time of sale or retirement from practice?*** No. There are no requirements, under Florida law, to obtain consent

when transferring medical records when a medical practice changes ownership. According to the Florida Medical Association and the Federal Register "Health Care Operations: Changes of Legal Ownership" the "sale, transfer, consolidation or merger" of a covered entity are considered health care operations. Thus, the "covered entity may use or disclose protected health information in connection with a sale or transfer of assets..." and "transfer records containing PHI as part of the transaction" without the patient's written authorization.

***How does the Americans with Disabilities Act of 1990 (ADA) affect a solo medical practice?*** The ADA labor provisions do not affect employment practices for businesses that have less than 15 employees. However, the practice is considered a public accommodation and is generally required to be accessible to disabled patients. Barriers to access must be removed if alterations are "readily achievable", which is determined by considering factors such as the nature and cost of the action, the owner's and tenant's financial resources and the impact of the action on the operation of the business. Such accommodations might include installing a ramp, making curb cuts, widening doorways, and modifying restrooms. Generally, these accommodations are made at the expense of the building owner. In most cases, local commercial building codes require such accommodations and

*(Continued on page 8)*

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may preempt ADA requirements.

**Is a physician excused from errors and omissions in reports and correspondence stamped "Dictated But Not Read"?**

No. The author will be held responsible for the contents. Use of such a stamp does little more than announce that the report or correspondence is incomplete.

**Does a change in employment affect a Physician Assistant's (PA) prescribing privileges?** Yes. Under Florida law, prescribing privileges are granted to a PA working under the supervision of a specific physician or physicians. A change in employment requires that the new employer/supervising physician delegate prescribing privileges to the PA, and the necessary application submitted to the PA's licensing authority.

**Are e-mails pertaining to a patient part of the medical record?** Yes. All forms of electronic communication and information exchange, when in connection with a patient's care and treatment, are considered personal health information and thus considered part of the medical record, subject to the same legal requirements and HIPAA privacy provisions as a traditional, hard copy.

**What is Florida's Legible Prescription Law?** FS 456.42 sets forth specific requirements pertaining to written prescriptions for medicinal drugs. Essentially, the law requires that a written prescription be legibly printed or typed; contain the name of the prescribing practitioner, the name and strength of the drug prescribed in both textual and numerical formats, and the directions for use of the drug; must be dated with the month written out in textual letters; and must be signed by the prescribing practitioner on the day when issued. •

**Florida Closed Claim Analysis – All Medical Professional Liability Claims • Total MPL closed claims: 3,753 • \$676,942,154 indemnity paid • \$449 M (66%) Economic damages • \$227 M (31%) Non-economic damages • ALAE: \$133,984,552 (19.8%) • Data is not complete.**

Florida Office of Insurance Regulation 2006 Annual Report – November, 2006

**WE'RE ON THE WEB!**

**FLSIPP.ORG**

# FSIPP NEWSLETTER

To Contact Us: [info@flsipp.org](mailto:info@flsipp.org)

