

FSIPP NEWSLETTER

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President's Message *Deborah H. Tracy, MD, MBA*

In my years of leadership activity as a physician, this one has certainly been the most challenging.

A combination of events including the Healthcare Reform Legislation, the continued threat of SGR cuts as well as the Florida Statutes, and the BOM/BOOM Regulations and Rules regarding "Pain Clinics" has consumed the passion of both FSIPP and myself.

Important to the FSIPP membership and placing huge responsibilities on pain management physicians are the Rules from the Florida BOOM that went into effect on November 8, 2010, and the rules promulgated by the Florida BOM Rules which are now on hold secondary to HB 1565 (a bill that will consider the economic impact of any rules on the small businesses of Florida). While the membership agrees that pill mills MUST be stopped and there is a panendemic of prescription drug abuse in our state, it appears that the Rules are so cumbersome they may help solve the 'Pill Mill' problem, but they may also shut down qualified, legitimate pain management facilities.

FSIPP has representation in Tallahassee and has retained an attorney to attend the BOM/BOOM meetings (along with the FSIPP Board of Directors). The FSIPP Board has attended all FMA meetings, activities and teleconferences. We expect there to be continued adjustments to both the Statutes and Rules hopefully easing some of the difficulties in implementing these regulations.

The Pain Truth Campaign, launched by FSIPP in September, is a nonpolitical endeavor to:

provide public education and awareness of the prescription drug abuse crisis in Florida, provide a resource for victims of the prescription drug abuse crisis, to educate the public about the issue of chronic pain, to alert teenagers of the dangers of addiction and to prevent unnecessary deaths and saves lives. Please see the article within this edition of the Newsletter.

Finally, we are preparing for our FSIPP Annual Meeting at the Gaylord Palms on May 13, 14, 15, 2011. Last year many of you commented that it was the best meeting of your career. We hope to beat that this year and with your help and attendance, network to plan our strategy for the future. Until then Happy Holidays, Peace and Good Health.

Deborah H. Tracy MD, MBA



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**FSIPP 2011 Annual Meeting
Conference & Trade Show
May 13-15, 2011
Gaylord Palms, Kissimmee**

Be sure to save the dates of May 13 – 15, 2011, for FSIPP’s Annual Meeting, Conference & Tradeshow, to be held again at The Gaylord Palms, Kissimmee (Orlando). The event will kick off Friday evening, May 13, with a Welcome Reception and a presentation on The Health Benefits of Wine!

Continuing education lectures will go on all day Saturday and Sunday morning, as has been our format for the last couple of years. We’ve had some very good feedback about the educational content of our meetings, and the 2011 meeting is shaping up with some exciting topics:

- “Soft Tissue Pathology”
- “The Musculoskeletal Physical Exam with Pearls”
- “An MCO Medical Director’s Perspective on Pain Management – Medical and Interventional”
- “Clinical Research Breakthroughs/Updates:
 - 1) NonParesthesia SCS...The Blinded Study IS Possible!
 - 2) Spinal Stenosis...Inject or Decompress - Results of RCT Comparing ESI to MILD,”
 - 3) Intradiscal Fibrin Glue”
- “The Evolution of Epidural Lysis of Adhesions”
- “The Dangers of Transforaminal ESI”
- “The Florida Statutes, DOH Regulations, and BOM/BOOM Rules Regarding Pain Clinics”

Don’t Miss It!

***Florida Statutes, DOH Regulations
And BOM/BOOM Rules For Pain Clinics
By: Sanford M Silverman, MD, FSIPP President-Elect***



The new pain clinic registration law (formerly known as SB 2272), now Statutes 458.3265 and 459.0137 went into effect on October 1, 2010. This legislation requires pain clinics to register with the Florida Department of Health and empowers the BOM/BOOM to create rules to regulate pain clinics in the State of Florida. There are also several ominous requirements in the legislation which will unduly encumber many of us. Examples include the following:

1. The department may revoke the clinic’s certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at any clinic location, based upon an annual inspection and evaluation. In other words innocent practitioners by be guilty by association.
2. A person may not dispense any medication, including a controlled substance, on the premises of a registered pain-management clinic unless he or she is a physician licensed under chapter 458 or 459.
3. A physician must perform a physical examination of a patient on the same day that he or she dispenses or prescribes a controlled substance to a patient at a pain-management clinic.
4. The BOM/BOOM must determine the maximum number of prescriptions written in a 24 hour period per physician and the physician practice must keep a log of all schedules II, III and alprazolam prescriptions written.
5. After 2012, all pain management physicians (unless meeting the prior BOM/BOOM requirements for grandfathering) must have fellowship training.

In addition to the legislation, the BOOM has implemented rules regulating pain clinics, effective November 8, 2010, with many requirements to include, but not be limited to:

1. UDT at the initial consult and randomly twice a year
2. Mandating a QA program which must be certified by a Florida Risk Manager every 3 years.
3. Mandatory discharge of a patient for diversion of prescribed controlled substances.
4. Mandatory referral of a patient to a BC pain specialist, addiction specialist, or addiction treatment facility if UDT shows illicit drug
5. Mandatory reporting to the DOH on a quarterly basis of:
 - New patients receiving controlled substances for non-malignant pain
 - Repeat patients receiving controlled substances for non-malignant pain

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- Patients discharged for diversion
- Patients discharged for abuse
- Patients whose domicile is outside of FL.

As a result of the legislative override of the Governor's veto of HB 1565, the BOM Rules, both standards of practice and registration, will at least temporarily come to a halt. At this point we do not know how long the delay will last. The proposed Board of Medicine rule on practice standards did not become effective on November 28th as was expected.

In addition to the above State Regulations, local municipalities have established moratoria and ordinances further encumbering pain physicians from opening new practices. Not all of these are uniform, however, and a significant number EXCEED the requirements established by the State, with respect to additional fees and permitting costs. These may be challenged in the future based on restriction of trade arguments.

The GOOD news is that the legislation is working. Anecdotal reports to this author from attorneys and law enforcement show the closure of significant numbers of "pill mills." In particular, the DOH is closing clinics that have failed to register with the State. The reason for all of this was to protect the citizens of Florida from prescription drug abuse, which claims the lives of nearly 7 persons daily.

You're Needed On the Frontlines of The Pain Truth
By Lora Brown, MD

- 76-million Americans Experience Chronic Pain
- Florida has the Highest National Rate of Prescription Drug Abuse
- Almost 3,000 Floridians Died from Prescription Drug Use in 2009

The Pain Truth, brought to the State of Florida by the Florida Society of Interventional Pain Physicians is fighting to make a dramatic decreases to these staggering statistics. **The** statewide community campaign aims to bring the prescription drug addiction epidemic to the forefront. As you are well aware, prescription drug addiction knows no boundaries. By banding together, we as a community will have greater power to educate, to influence and to put an end to the deadly epidemic.

So far, The Pain Truth has had a great deal of television, print, internet and radio news coverage. Visit the "In The News" page of ThePainTruth.org to see specifics. Three public service announcements have been produced and are being distributed throughout the state. And we've also begun a young adult program called *Wake Up!*, targeted towards teens and college students. It is being packaged in the form of a PowerPoint presentation and Video & Educational booklet and should be available for use in December. If you are interested in taking the program into schools in your area, contact us for assistance or more details.

By now, all FSIPP members should have received a package of educational materials for your offices, including an identifying door/window cling, an office poster and patient flyers. Should you need more, please call. The Pain Truth program encourages each of you to contact your local media to request stories on The Pain Truth programs and call your local television station General Managers to ask them if they would please run the Pain Truth PSA's. We'd love for you to be a greater part of The Pain Truth efforts.

ThePainTruth.org is updated several times a week, so be sure to check the site often to view the PSA's, your listing as a pain physician, a sampling of the news media hits and much more.

Electronic Medical Records

Early in President Obama's term 'The American Recovery and Reinvestment Act' passed through Congress. This bailout bill contained several provisions for healthcare including promoting the adoption of electronic medical records. Since that time CCHIT and the Drummond Group have been recognized as certifying entities for 'meaningful use' and physicians are busy at the task of evaluating EMR products. Some physicians are eager to move forward and some have decided that the cost is too great if retirement is a consideration. Additionally, medical societies, hospitals and other entities are forming Health Information Exchanges (HIEs) to serve as portals for information to be secured and passed through. Be sure when you choose and buy an EMR that the cost includes your ICD 10 update and an interface for your HIE.

The following is a chart for the most recent review on what is considered 'Meaningful Use:'

Summary Overview of Meaningful Use Objectives.*	
Objective	Measure
Core set†	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it

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On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR’s capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures
Menu set‡	
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for hospitals and critical access hospitals	
Record advance directives for patients 65 years of age or older	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded
Submit of electronic data on reportable laboratory results to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for eligible professionals	
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

* This overview is meant to provide a reference tool indicating the key elements of meaningful use of health information technology. It does not provide sufficient information for providers to document and demonstrate meaningful use in order to obtain financial incentives from the Centers for Medicare and Medicaid Services. The regulations and filing requirements that must be fulfilled to qualify for the Health IT financial incentive program are detailed at www.cms.gov.

† These objectives are to be achieved by all eligible professionals, hospitals, and critical access hospitals in order to qualify for incentive payments.

‡ Eligible professionals, hospitals, and critical access hospitals may select any five choices from the menu set.



Reading Room

CMS Complicates Billing Wastage for Drugs

Effective July 30, 2010, CMS has amended its policy on billing for discarded drugs and biologicals per CMS Transmittal 1962, issued on April 30, 2010. However, the rule has a quirky “catch” that could result in inadvertent overbilling. The amendment provides the following.

1. The amendment only applies to single use vials in which part of the drug is administered and part is wasted.
2. It allows your MAC (Medicare Administrative Contractor) to require the use of the JW modifier to indicate the wasted amount.
3. The mechanics of the usage of the JW modifier require that portion of the drug which is administered to be billed on one line without the JW modifier, whereas, the wasted amount is billed on a second line item with the JW modifier (“The JW modifier is only applied to the amount of drug or biological that is discarded”).
4. CMS’s Example: “a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units may be billed on another line by using the JW modifier. Both line items would be processed for payment.”
5. However, the quirky part of the rule which is apt to lead to overbilling is that the combined units of the billed administered amount and the billed wasted amount cannot exceed the total units which would otherwise be billable if the entire vial was used. CMS gives the example of a drug where the billing unit is one unit per 10 mg. Assume that 7 mg are administered, and 3 mg are discarded. You cannot bill 1 unit of the administered drug and then another unit for the discarded amount, because to do so would result in 2 units (20 mg) being paid by Medicare, because Medicare is going to process both line items for payment. In the instance where billing the used and discarded amounts would result in billing more units than purchased, don’t use the second line with the JW modifier. CMS says, “Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.” In other words, the only time one would use the JW modifier is where the billable units for the administered amount and the billable units for the discarded drug are equal to or less than the total units which could have been billed if all of the drug had been administered.
6. This is a complex rule, and in my opinion, is a recipe for inadvertent overbilling, so make sure your billing staff is aware of the idiosyncrasies of this rule. They are going to have to know how much of the drug, as per the HCPCS Manual, equates to 1 billable unit in order to know whether they can bill units for both the administered amount and the wasted amount. If the billed units for the administered amount and the billed units for the wasted amount exceed the total units for amount of the drug purchased, they cannot bill the wasted amount.

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UHC and MedAssurant Audits

MedAssurant is an audit company. They are doing two types of audits, both of which involve on-site visits. One audit is of no consequence; the other is.

The audit that you don't have to worry about is the one where MedAssurant is auditing on behalf of an insurer which is a Medicare Advantage program. In this audit, MedAssurant is only trying to get more money from Medicare, which it

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can do it if can "jack up" the intensity of the diagnosis code it finds in your charts. So, in this type of audit, MedAssurant is not looking for money from you.

In the other type of audit, however, where it is auditing high level E&M codes for UHC, the auditor is looking for money from you, and you do need to be aware of how this works. I just had a client to email regarding his experience, and here is what he had to say:

"I wanted to give you an update on the MedAssurant/United audit, so you can serve your other clients better. Last Friday we had the first day of the audit. I have spent my whole day with the auditor. It was a wise decision. United has asked MedAssurant to do an audit on high level E/M services, levels 5 or level 4 (some new patient, some follow-up care). When I called the MedAssurant representative (Ms Latoya) few weeks ago, she did not want to tell me that it would be high-level E&M services. The auditor told me that most of the audits that they are doing are for high level E&M services. Here is how they do it: They pick one day of service and then drill it down to a very detailed level. Then, they ask for records a few months before and after that day of service. Then everything has to be scanned. The problem is that the auditor has a tendency to scan very limited amounts of info in the system (because it is very time consuming) and if there is not enough info scanned, then the documentation might not support the complexity of care and level of service charged. MedAssurant is using software which is designed (by type of questions asked) for use in an Internal Medicine/Family practice, not for sub-specialties. I am familiar with AMA standards of coding and billing for each level of service, and I can tell you that this MedAssurant software goes into way more details. They have twisted some questions against physicians when they are doing an evaluation of complex medical management and decision making. This is another disadvantage. If I would not have been there, the auditor would not be able to do an accurate job. BTW, the auditor is a RN who has been doing audits for 1 month only. We did only 9 patients in one day (due to the very time-consuming scanning process). My advice to your other clients: the physician has to be there!! Also, it is a great learning experience."

Knowing most of my clients, the physicians are not going to spend an entire day with the auditor. However, if you have a certified coder or other knowledgeable coding person available, it would be beneficial for them to sit with the auditor during this process. These MedAssurant auditors may not know the complexities of chronic pain medical decision making; they purportedly are using software designed for internal medicine; and they may not scan all the relevant information in the chart unless someone is present to guide them.



Having Good Intentions but Not Doing Anything Right: A Claims Perspective of a Pain Management Case

Over 3.6 billion prescriptions are filled at pharmacies in the United States, and 6.1% of these prescriptions are filled in Florida. For every 1000 prescriptions written, 40 involve a medical error. For every dollar spent obtaining a medication, \$1.33 is spent to treat a resulting adverse drug event. Medication errors are more common than one would like to think. The following is a case study of a recently closed pain management claim involving a medication error. The claim illustrates how actions a physician believes to be innocuous can in fact be dangerous, and the importance of adhering to federal, state, and local rules and regulations regarding medication management.

Background: An active elderly woman presented to a pain management physician due to long term posterior back pain. An intrathecal fusion pump trial was recommended. Shortly thereafter, the patient underwent the first in a series of trials to determine which medication was the most effective for her condition. Morphine sulfate was administered.

The administration of the morphine sulfate was uneventful; however, in the recovery room, the patient experienced dizziness, a drop in blood pressure, and nausea. Hours after being stabilized and discharged, the patient was transported via EMS to the emergency department where she received a morphine reversal agent and fluids. The pa-

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tient was admitted to the intensive care unit due to continued lethargy and unresponsiveness. She was diagnosed with narcotic overdose, aspiration, encephalopathy, acute renal insufficiency, and urinary retention. While in the intensive care unit, the patient developed cardiac complications. She was stabilized and discharged. A few weeks later, she developed seizures, became unresponsive, and ultimately died.

The physician had the vial of morphine sulfate tested by an external laboratory. The laboratory determined the morphine was more than 10 times more potent than labeled. The physician informed the husband of the results, and the husband later brought suit against the pharmacy.

Complicating Factors: During the lawsuit against the pharmacy, the deposition of the pain management physician was requested. The physician did not notify his insurance carrier of the incident prior to the deposition, and instead, attended the deposition with his practice's corporate counsel. At the deposition, the physician admitted the single use vial of morphine sulfate used for this patient had been ordered for another patient, and it also was used on two other patients. One of the patients died as a result of narcotic overdose. The pain management physician further testified that the morphine sulfate was expired at the time it was administered. He admitted under oath that the administration of another patient's expired medication was a deviation from the standard of care.

Subsequent to the deposition, he was sent a Notice of Intent to Initiate Litigation ("NOI"). The NOI claimed the pain management physician deviated from the acceptable standard of care through his failure to administer the morphine prescribed for the patient, failure to administer the correct dose of morphine to the patient, administering another patient's prescription to the patient, and administering a prescription that was expired to the patient.

Resolution: This case ultimately was settled on behalf of the pain management physician and his professional practice. Although the pharmacy was likely the source of the error, the defense was unable to find an expert willing to support the standard of care in a case where an expired, single dose medication was administered to multiple patients resulting in their demise. The actions of the physician were contrary to federal, state, and local rules and regulations. There were significant economic damages involved in the case; therefore, the carrier chose to protect the interest of the physician by negotiating an early resolution of the claim.

Lessons Learned: While the actual claim is replete with risk management issues, three lessons can be taken from this claim study. Although the physician had good intentions with his actions, these three actions made the defense of his medical negligence claim relatively unmanageable, and all of these actions were within his control:

Reuse of Single Dose Medication Vials. The physician testified that he reused single dose medication vials prescribed to other patients to save his current patients time during their intrathecal fusion pump trials. Do not reuse single dose medication vials prescribed to another patient, regardless of the reason. While this might seem to be common sense to some, the reuse of single dose medication vials remains pervasive. In 2008, the Centers for Medicare & Medicaid Services ("CMS") piloted an infection control audit tool in a sample of ambulatory surgery center inspections in New Jersey to assess facility adherence to recommended practices. 28.1% of the facilities inspected were cited for using single dose medication vials for more than 1 patient. Additionally, in an online poll conducted by *Outpatient Surgery Magazine*, 77% of the facility managers responded that his or her practice reuses single dose medication vials.

Use of Expired Medications. In his deposition, the physician testified he routinely administered expired medications to his patients because the only effect would be lowered efficacy. Expired medications should never be administered to patients, regardless of how harmless doing so may seem. There is no way to determine if an expired medication is effective, less potent, or harmful after the expiration date. Protect yourself, your practice, and your patients- discard all expired medications.

Incident Reporting. In this case, the physician did not notify the carrier of the incident or his deposition, despite the fact that he was aware a medication error occurred during the course of his care and treatment of the patient. Physicians should immediately report an adverse incident to his or her medical professional liability carrier. Such notification not only allows the insurance carrier to monitor the situation and ensures the physician has coverage, but it also allows for possible prevention of a lawsuit through utilization of risk management resources. One should never assume that he or she will not be included as a named party in an ongoing lawsuit at a later point, as the physician did in this case. Notifying the carrier will ensure an attorney experienced in medical negligence actions is present to protect the interest and rights of the physician from the outset.

The practice of medicine can be unpredictable. A physician can perform his or her job correctly, and still obtain a bad outcome because of circumstances beyond his or her control. In this case, the physician could not control the pharmacy error or the fact that it more than likely would have resulted in a death if administered to the prescribed patient. Yet, he could control the fact that an expired single dose medication was administered to three individuals, two of whom died because of the initial pharmacy error. By not adhering to federal, state, and local rules

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and regulations, he created a situation in which it was relatively impossible to provide a defense on the standard of care, despite the questionable causation.

Most physicians will be involved in a medical negligence claim during the course of his or her career. The medical negligence claim will likely involve a close scrutiny of the policies and procedures of the practice, and the actual actions of the physician. Physicians and their practice managers should do a close analysis of their practice to ensure such rules and regulations are strictly being followed.

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It's a Buyer's Market

***Melodee S. Dixon, CPCU, AIAF, ARE, ARC, ASLI
Chief Operating Officer & Actuary,
Florida Doctors Insurance Company***

Insurance is a cyclical business. Today's conditions are known as a "soft market," meaning coverage is available and affordable. The level of competition is reasonable and fair. The carriers are specialists in medical professional liability insurance. This is quite a change from just 10 years ago.

In 2000, carriers were reporting record profits, which were mostly driven by results from the late 1990s. These reported profits attracted professional liability specialists from other states and large, national property & casualty firms with little or no experience in medical professional liability. All were eager to make the same returns. At its peak, the market had over 60 insurers vying for business at "ridiculously low" prices. These prices proved to be unsustainable because the number of claims, or frequency, and the cost of claims, known as severity, was rising dramatically. The crisis for medical professional liability insurance was just beginning.

Just two years later, Florida's market was in shambles – most carriers had either left the market or filed for bankruptcy. In many cases, coverage was not even available. If you found coverage, it was not affordable. In 2003, the Legislature began to address the crisis. Senate Bill 2-D was passed, which implemented a cap on non-economic damages. From time to time, you may still hear about large awards in the news. Most of these cases were filed before the cap was implemented or involve large economic damages. There have been some challenges to the constitutionality of the cap on damages; however, it remains in place and continues to benefit physicians.

Between 2003 and 2007, the number of claims filed against physicians dropped dramatically. The cost of claims stabilized. In 2005, new carriers such as Florida Doctors Insurance Company were capitalized and entered the market. Our management team, made up of insurance professionals with experience in Florida, recognized the impacts of the reforms. Our goal was to offer insurance coverage at a price that reflected these lower cost drivers, while providing the physicians with a partner who understood the challenges they faced in today's tough economic conditions.

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For the last five years, we have exceeded those goals. Nearly 3,000 physicians have placed coverage with Florida Doctors Insurance Company. On average, prices have decreased over 40%.

There has been an increase in the number of claims since 2008 and claim costs have risen slightly. We expect similar market conditions to continue for another 12 to 18 months; however, insurance is a cyclical business. The "hard market" could be just around the corner. No one definitely knows.. Check with your independent insurance agent now to ensure that you have taken full advantage of today's market conditions.

WE'RE ON THE WEB!

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FSIPP NEWSLETTER

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2011 FSIPP Annual Meeting, Conference, & Tradeshow - May 13 - 15
2012 FSIPP Annual Meeting, Conference, & Tradeshow - May 18 - 20

