



February 2012

MIAMI MEDICINE

The Official Publication of the Dade County Medical Association

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POSITION DESCRIPTION

The Chief Medical Officer and Epidemiologist is an executive position within the Miami-Dade County Health Department (MDCHD) reporting to the MDCHD Administrator and planning and directing the program of Epidemiology and Public Health Services.

The Epidemiology Program identifies and analyzes disease trends and implements interventions to promote and protect the health of Miami-Dade residents. The Epidemiology Program acts as a resource for health care providers and the public regarding health questions and issues, and provides public health education and messaging. The Medical Director plays a major role in maintaining the Health Department's partnerships with the medical infrastructure, other government agencies, and Miami-Dade's citizens.

DUTIES AND RESPONSABILITIES

- Develops public health policy and conducts long-range planning for the Health Department. Plans, organizes, and directs public health and preventive health activities. Oversees budgets and program funding acquisition.
- Oversees project and programs progress. Participates in professional organizations and obtains and disseminates information on current and future healthcare practices and trends. Provides consultation to physicians and other healthcare providers in the community concerning medical and public health issues.
- Provides presentations to medical and public health practitioners as well as to members of the public. Provides medical and public health leadership and consultation during public health communicable disease crises and/or emergencies and participates in emergency response activities and planning.

QUALIFICATIONS

The ideal candidate must have experience in public health management, communicable disease control and epidemiology, and clinical medicine and possess the following:

- M.D./D.O Licensed in the State of Florida is required.
- Administrative and supervisory experience is required.
- At least 5 years of experience working in the field of communicable disease control and epidemiology at a federal, state, county or city level is required.
- Board eligibility in specialties such as Pediatrics, Internal Medicine, Infectious Disease, Family Practice, Public Health and General Preventive Medicine is required.
- Master's Degree in Public Health or related field from an accredited school of public health (one year of experience as a Medical Officer in a public health agency may be substituted for the Master's Degree).





Beny Rub, M.D.

President, Dade County Medical Association

MESSAGE *from your* PRESIDENT:

by Beny Rub, M.D.

2012: A YEAR IN THE MAKING

2012: a year in the making. With each year that passes our challenges continue to grow. Our desire to make a better working environment gets energized! Our desks get cleaned up; our outlook at closing a difficult year and looking for a better one is admirable.

So this year we need to get the job we are all waiting for done: **GETTING INVOLVED.** Getting involved means being a part of our society, our community, our county, our state and our country. Therefore, at any level you want to do it, let's do it together. All of us have many different commitments to family, work and profession. Let's make this year a year of spending time to have a direct impact on your future. Let's start directing traffic, let's ask and tell our legislators why pro-medicine and pro-physician legislation is the right way to vote; not just because we take care of their ill's and their medical problems, but because it is the right way to care for our citizens of the State of Florida.

This is an important year to deal with issues such as sovereign immunity for physicians treating patients in the emergency room. It is the year to enact car seat safety measures for children

ages 4 to 8. We are not considering increasing the scope of practicing medicine by other practitioners except for DO's and MD's; we continue to oppose expansion of the Medicaid Pilot Program to all counties in Florida; and to ensure "dual eligibles" (patients covered by both Medicaid and Medicare) are not included in the Medicaid Pilot Program. These and many more are issues that the DCMA, with the force of the FMA, will be dealing with in Tallahassee this legislative session.

Yes, we have an economic crisis that our Governor and our legislators have to work on to balance the budget, but achieving this balance needs to be fair, reasonable and sensible. We have to make it practical and we have to make it feasible. So continue practicing good medicine, join us to increase our strength and our representation and together we will succeed in our mission to care for our patients and practice with dignity and respect.

Beny Rub M.D. *President,
Dade County Medical Association*

CORRECTION

On page 9 of the January 2012 issue of Miami Medicine, the incorrect author's name was published for the article titled: Are You Ready for the New ICD-10 and Electronic Version 5010? Changes Start Taking Effect in Early 2012. . . The article was written by **Robert J. Conroy, Esq., Denise Sanders, Esq., Matthew R. Streger, Esq., and Peter D. Espey, Esq.** The authors of this article may be contacted at 1 800 445-0954 or via email – info@drlaw.com. The DCMA regrets this error.

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Symposium Directors

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For symposium details and registration, go to MiamiCVDPrevention.BaptistHealth.net or call 786-596-2398.



Baptist Health South Florida

You Don't Need to be a Cardiologist

By Paul A. Kurlansky, M.D., Director of Research, Florida Heart Research Institute

Years ago there was a very sharp advertisement for a rye bread that used to feature quaint pictures of people of various ethnic origins enjoying a deli sandwich on rye bread with the caption: "You don't have to be Jewish to enjoy Levy's rye." Cardiovascular disease remains the leading killer of men and women in this country and increasingly throughout the world. Although there have been remarkable advances in diagnosis and treatment, and resultant decline in mortality over the past quarter century, there remains one aspect of this disease which, despite fifty years of medical attention, has escaped therapeutic success: Sudden Cardiac Arrest (SCA). The incidence is high, estimated to represent between a quarter and a third of a million victims per year. The outcome?

Despite extensive networks of 911 responders, advances in cardiopulmonary resuscitation, introduction of emergency coronary interventions, and, most recently, the use of induced hypothermia to preserve brain function, the astonishing fact is that the nationwide average survival from SCA hovers around 7%. Moreover, that number can vary more than ten-fold depending upon the community examined.

Clearly, this is not merely a problem for cardiologists; this is an issue which requires the collective efforts of the entire medical profession. If a person should drop in front of you, not breathing and unresponsive, would you know what to do? Would your patients know what to do if it happened to their parents, or children, or siblings? The core of the challenge relates to that which we all learned in medical school. The brain is exquisitely sensitive to diminished perfusion. Six minutes without circulation at normothermia and brain cells will begin to suffer irreparable damage. Every minute that a victim suffers from absent circulation, chances of survival diminish approximately 10%. By the time the cavalry arrives, the battle is frequently already lost. Yet, if a patient is found with a shockable rhythm, his chance of survival in Rochester Minnesota or Seattle Washington approaches 50%. How can this happen?

The most critical step in what has been referred to as the "chain of survival" is the recognition of cardiac arrest, the immediate call to 911, and the immediate institution of effective resuscitation. What has changed recently is the nature of what is considered effective resuscitation. Whereas the "ABC's" of CPR traditionally required clearing of the airway, instituting breaths and then starting chest compressions, extensive animal and clinical evidence has radically altered the paradigm. The immediate institution of chest compressions—over the sternum, 2 inch depth in adults, with complete

release, 100 or more times per minute (ironically the actual rhythm of the Bee Gees hit "Staying Alive" works quite nicely) will temporarily decompress the distended fibrillating (and therefore ischemic) heart, restore critical circulation to core organs (especially the brain) and,

through bellows action, actually supply adequate ventilation with an open airway sufficient to support circulation. No mouth-to-mouth is necessary. Fear of contracting disease is no longer a concern. The next step is the call for a defibrillator. The current generation of external defibrillators are somewhat self-explanatory. They show how to position the pads (no paddles) from which they will read the rhythm and instruct if and when to deliver a shock (most current machines also deliver biphasic shocks, which have

proven more effective). All of this can, and, to a certain degree, must be accomplished before the arrival of the 911 if the patient is going to have a reasonable chance of meaningful survival.

When the fire rescue squad arrives, they will concern themselves with continuing the chest compressions as necessary (monitoring effectiveness with capnography once airway is established), starting IVs, administering medications, further administration of shocks if needed, and transporting to the nearest ER. A well-organized system will transport to the nearest hospital capable of prompt catheterization (if indicated) and induced hypothermia if the patient has not been restored to consciousness. However, the success of all of these latter efforts rest upon the prompt bystander recognition of SCA, calling of 911 and institution of what we at the **Florida Heart Research Institute** call PUSH CPR®. Upon request, FHRI will send a team to teach PUSH CPR® to groups of 20 or more in a brief 15 to 20 minute presentation.

As a medical student, I remember being concerned not to leave each of the major rotations without knowing how to manage a situation that, regardless of my chosen specialty, could help to save a life: to recognize and respond to suicide risk, epiglottitis, meningococcal meningitis, imminent delivery, bleeding, and, of course, cardiac arrest. What has changed over the intervening years (more than I would dare to confess) is that the methodology for responding to SCA has evolved. Now, you don't need to be a cardiologist, you don't need to be a medical student, you don't even need to be medical professional of any type, in order to save a life – help us spread the word! For more details or to schedule a demonstration, go to www.pushcpr.org or call (305) 674-3020.

Paul A. Kurlansky, M.D. can be reached at 305 674-3154 or via email at doctorwu18@aol.com.



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A Tragic Lesson in Drug Safety

By David B. Troxel, MD, Medical Director, The Doctors Company



A four-year-old female with a history of asthma presented with her mother to our insured pediatrician for treatment of a barking cough (croup). The pediatrician prescribed Tussionex, one-half teaspoon once a day. The following day at 6:30 PM, the office nurse telephoned the residence and spoke with the mother, who reported the child was much better and was running around. The next day, the mother found the child unresponsive and summoned the emergency squad. They administered CPR and transported the child to the hospital, where she was pronounced dead. An autopsy revealed the child had toxic blood levels of hydrocodone and chlorpheniramine (components of Tussionex) and diphenhydramine (an active ingredient of Benadryl).

It was alleged the insured pediatrician failed to heed the warnings and recommendations of the manufacturer of Tussionex, including explicit warnings against its administration to children under the age of six; that he failed to heed the warnings of the Food and Drug Administration (FDA) and the American Academy of Pediatrics against prescribing Tussionex to children under the age of six; and that he prescribed an excessive dose of Tussionex based on the child's age and weight.

Defense Experts

A pediatrician expert stated he had no issue with the insured prescribing Tussionex to a child this age. He said the *FDA Alert* regarding Tussionex was released just a week before this event occurred, and he felt it was understandable that the insured was not aware of it. He also did not believe the standard of care required the insured to be aware of the *FDA press release* on Tussionex (released three months before this event) or the notice posted on the *FDA Web site*. However, he believed the insured was responsible for knowing the contents of the *FDA "Dear Provider"* letter that had been sent within a week of this prescribing event. He also questioned whether a physician is responsible for reviewing each medication he prescribes when a new edition of the *Physicians' Desk Reference* (PDR) is released.

A toxicology expert stated that both the Benadryl and the antihistamine in the hydrocodone are inhibitors of metabolism of hydrocodone. The toxicologist concluded the amount of hydrocodone found in the blood meant that the child had 3.4 doses in her body at the time of death, which is more than would be expected based on the dosage prescribed. He made similar calculations with regard to chlorpheniramine and concluded there were approximately 4.8 doses at death. Chlorpheniramine has a longer half-life than hydrocodone, which could account for the difference.

A pediatric neonatologist felt it was a breach of the standard of care to prescribe Tussionex to this child. He said slow-release narcotics can accumulate in the system and lead to respiratory depression, which is aggravated by the child's age, by other drugs in the mixture, and by Benadryl. There is no safe amount to prescribe. The specific drug for croup (when it is very bad) is a corticosteroid; otherwise a vaporizer and observation are the standard of care.

The pharmacy that filled the prescription was a co-defendant. Its pharmacist received an electronic Drug Utilization Review (DUR) Alert requiring him to contact the physician regarding the safety of the prescription. He entered "prescriber contacted, prescribe as is" to override the Alert and filled the prescription without calling the insured.

Plaintiff's Experts

A forensic pathologist and a toxicologist from the coroner's office believed there were toxic-to-lethal blood levels of the components of Tussionex, which caused the child's death.

A pediatrician opined that the insured should never have prescribed Tussionex to this child, adding that this drug should never be considered for any child under six years of age. He could not say if the proper dose was one-quarter teaspoon rather than one-half teaspoon, but he opined that the insured prescribed twice as much as he should have based on the child's weight. He added that it was not appropriate to recommend using Benadryl as a sleeping aid in a child. (Our insured did not remember ever making this recommendation, while the parents alleged that he did.)

Should This Case Be Tried?

The death of a four-year-old child is tragic and would be viewed as such by a jury. While there was one expert to support the insured's lack of knowledge of the multiple warnings against using Tussionex in children, the plaintiff's counsel had multiple experts to state the contrary. Furthermore, the PDR in the insured's office contained the warning, and a jury would likely expect a physician to be fully knowledgeable about medications being prescribed and the dangers contained therein. The insured would be susceptible to the question, "Doctor, who is responsible for knowing about a medication that is prescribed to a patient?" Clearly, the correct answer is the physician who is prescribing it. With the insured's consent, the case was settled.

Discussion

Each year, almost 25 percent of drugs have clinically relevant changes made to their FDA-approved labels. FDA-approved labeling is

often the standard to which physicians are held in claims involving medication errors. An analysis of all claims closed at The Doctors Company in 2010 revealed that 6.1 percent contained medication errors. The most prevalent claims in this category included giving the wrong medication (18 percent), failing to follow guidelines or protocols (16 percent), giving the wrong dosage (13 percent), errors in drug administration (12 percent), and ordering errors (5 percent). It is likely that some of these errors could have been prevented by keeping current on FDA-approved drug labeling.

We encourage our members to join the Health Care Notification Network (PDR Drug Alert Network) to receive their FDA Drug Alerts via e-mail. Physicians who participate are less likely to overlook an important FDA Alert, and they can earn continuing medical education (CME) credits for reading the Alert and taking a short online test on its content.

PDR Network hosts the CME programs, and The Doctors Company provides the CME credits to all U.S. physicians at no charge. These CME courses are available for physicians who are registered PDR.net users. For more information on this free service, visit www.PDR.net.

Implications for E-Prescribing Liability

The pharmacist overrode the DUR Alert and filled the prescription without calling the insured. This may be a harbinger of electronic health record e-prescribing liability risk, because there is a danger that doctors may suffer "alert fatigue"—and ignore, override, or disable alerts, warnings, reminders, and clinical decision support guidelines. If following an alert or guideline would have prevented an adverse patient event, the physician may be found liable for ignoring it.

David B. Troxel, MD, is secretary of the Board of Governors and medical director of The Doctors Company. Dr. Troxel is clinical professor emeritus of the Joint Medical Program at the University of California at Berkeley. He is past president of the American Board of Pathology and the California Society of Pathologists. He serves as chairman of The Doctors Company Foundation and as a member of the Technology Committee at The Doctors Company.

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Consignment Closets: Still a Viable Option for DME Providers

By Jeffrey L. Cohen & Albert R. Meyer, The Florida Healthcare Law Firm

In the age of heightened regulatory scrutiny, physicians and other health care providers often question whether “Consignment Closet” relationships are legal. If properly structured these arrangements are not only legal but are of great benefit to patients needing valuable medical devices. A properly structured relationship will, in all probability, withstand a regulatory challenge by the Office of Inspector General or from other regulatory authorities.

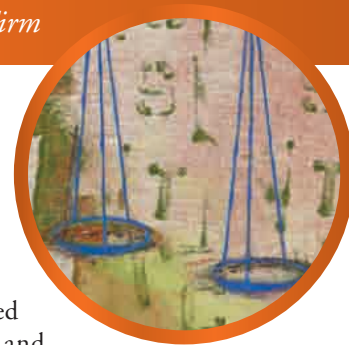
Consignment Closets or “Stock and Bill” arrangements are used by many durable medical equipment, prosthetics and orthotics suppliers (“DMEPOS”). The DMEPOS supplier places inventory in space rented from a physician’s office. This allows the patient to immediately receive equipment or devices that they need as they leave the physician’s office. The DMEPOS company, not the physician, bills the patient or the patient’s insurance carrier (or other third party payor) for the device. In proper Consignment Closet models the patient should never be forced to obtain devices from the physician’s office and are free to use the supplier of his/her choice. When a patient chooses to obtain the device at the physician’s office the physician’s staff will instruct the patient on the use of the device or “fit” a brace or other product provided. The DMEPOS supplier will compensate the physician’s office for this service, as well as for administrative services provided by the physician’s office staff for providing billing information to the DMEPOS supplier. The DMEPOS supplier also rents from the physician the space in the physician’s office where the DMEPOS supplier’s inventory is stored.

The relationship between the DMEPOS supplier and physician as described above can pass muster from a regulatory perspective as long as the arrangement complies with the Stark Law and the Federal Anti-Kickback Statute (“AKS”).

The Stark Law, in a nut shell, prohibits a physician from referring a Medicare or Medicaid patient for Designated Health Services (“DHS”) to an entity in which the physician or immediate family member of the physician has a financial relationship. DMEPOS are considered DHS for purposes of the applicability of the Stark Law. A financial relationship is one in which physician has an ownership or investment interest or a compensation arrangement. Under current interpretations and application of the Stark Law, services provided by the physician to the DMEPOS supplier will constitute a financial relationship between the physician and the DMEPOS company. This type of arrangement can fall into an exception to the Stark Law (the “personal services exception”) and be permissible if the following elements are incorporated into the arrangement:

1. The arrangement is in writing and specifies the services covered by the arrangement.
2. The term of the arrangement must be for at least one year.

3. The arrangement needs to cover all of the services to be furnished by the physician to the entity.
4. The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.
5. The compensation paid must be set in advance and be of a fair market value for the services provided and is not conditioned upon the volume or value of any referrals or other business generated between the parties.



As for the rental of the space to store inventory, the prohibitions under Stark are excepted if the following conditions are met:

1. There must be an agreement in writing for a period of at least one year.
2. The compensation must be of a fair market value based on usual rental rates for comparable office spaces in the community.
3. The transaction is commercially reasonable and furthers the legitimate business purposes of the parties.
4. The arrangement does not violate the Anti-Kickback Statute.

From the perspective of the Stark law, a consignment closet arrangement containing the elements discussed above will likely pass the scrutiny of federal regulators. It should be cautioned, however, that even a slight deviation from the structure mentioned above may result in civil and criminal penalties.

The Anti-Kickback Statute is a criminal statute that prohibits anyone to knowingly and willfully offer, pay, solicit or receive any payment, directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to another person for furnishing or arranging for the furnishing of any item or service or the purchasing, leasing ordering or arranging of any good, facility, service or item that may be paid for by a Federal health care program. The government implemented numerous “safe harbors” that exempts from scrutiny an arrangement which meets ALL of the specified standards. With the consignment closet arrangement, two safe harbors come into play. The first is called the “personal services safe harbor” and the requirements are similar to those of the Stark personal services exception. This safe harbor permits payments by a DMEPOS supplier to a physician so long as the following six standards are met:

Continued on page 10

Continued from page 9

1. The agreement is in writing and signed by the parties.
2. The agreement specifies the services to be provided by the parties.
3. If the agreement is intended to provide for service of the agent on a periodic, sporadic or part-time basis, rather than a full time basis, for the term of the agreement, the agreement must specify the schedule of such interval, the precise length and the exact charge for such intervals.
4. The term of the agreement must be not less than one year.
5. The aggregate compensation paid over the time of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business generated between the parties for which payment may be made in whole or in part under Medicare or Medicaid.
6. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

The other safe harbor is called the “space rental safe harbor.” It quite similar to the personal services safe harbor in that it requires:

1. The agreement is in writing and signed by the parties.
2. The agreement covers all of the premises rented by the parties for the term of the agreement and specifies the premises covered by the agreement.
3. If the agreement is intended to provide the lessee with access to the premises for periodic intervals of time rather than on a full time basis for the term of the rental agreement, the rental agreement must specify exactly the

schedule of such intervals, their precise length and the exact rent for such intervals.

4. The term of the rental agreement is for not less than one year.
5. The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business generated between the parties for which payment may be made in whole or in part under Medicare or Medicaid.
6. The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

It should be noted that while a properly structured arrangement may currently withstand regulatory scrutiny, regulators are closely examining consignment closet arrangements. In fact, in 2009 CMS issued a transmittal that essentially prohibited arrangements when a DMEPOS supplier maintains an inventory at the practice location that is not owned by the DMEPOS supplier, but by the physician. This rule required the physician to take possession of the DMEPOS items who then would have had to bill for the equipment using their own supplier billing number. In addition to placing additional administrative and regulatory burdens on the physician (e.g. becoming licensed as a DMEPOS provider), this arrangement may be deemed to be in violation of the Stark law.

Fortunately, CMS rescinded the transmittal and the rule described in the preceding paragraph is not in effect. CMS was scheduled to reinstate the so-called “consignment closet rule” in March 2010, but as of this writing, the rule has not been reinstated.

Therefore, unless and until the consignment closet rule is reinstated, DMEPOS suppliers and physicians are free to set up consignment closet relationships. However, DMEPOS suppliers and physicians must pay close attention that the Stark exception and anti-kickback requirements are complied with in the strictest possible sense.

The content of this article for informational purposes only and should not be considered legal advice. Each situation is different and it is recommended that you contact an experienced health care attorney to advise you on the subjects discussed in this article. Health care laws and regulations are subject to rapid change and the information transmitted in this article may not be applicable in the future.

Mr. Cohen and Mr. Meyer have over 45 years of combined healthcare legal experience, and have advised clients all over the United States regarding M.D./D.C. arrangements. With a strong and extensive background and expertise in transactional healthcare and corporate matters, particularly as they relate to physicians, the Florida Healthcare Law Firm is immersed in regulatory, contract, corporate, compliance and employment related matters of medical practices and other healthcare businesses. Mr. Cohen and Mr. Meyer can be reached at www.floridahealthcarelawfirm.com and also by calling toll free at (888) 455-7702.

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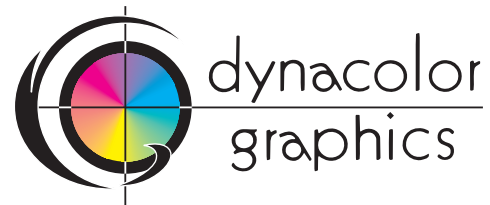
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What's New with the Florida Board of Medicine: Introducing Changes to the Board's Website



In 2011, the Florida Board of Medicine underwent many changes. One of those changes was a complete overhaul of our website based on comments received from our licensees as well as the general public. This article will provide you with an overview of the website so you can find information when you need it.

The web address for the Division of Medical Quality Assurance (MQA) is www.doh.state.fl.us/mqa. This site is the overview site applicable to all health care providers and from this site you can access many things:

- Renew your license
- Update your Practitioner Profile
- Update your address
- Designated yourself as a controlled substance prescriber
- Create a relationship between yourself and a pain-management clinic
- Request a duplicate license
- Request a license verification
- Access information on counter-proof prescription pad and approved vendor list
- New changes in law
- And much more . . .

Coming soon - The Board of Medicine's licensure applications will soon be online. This will allow applicants to complete the application and submit the fee with the application online.

The Board of Medicine web site can be accessed from the MQA site or by typing in the web address which is www.doh.state.fl.us/mqa/medical. To access it from the MQA web site, simply click on *Health Care Professions* and select *Medicine*.

Everything on this site is related to physicians. Below is a list of the categories available on this site and the types of documents that can be found under each category:

[Apply for License](#)

As mentioned earlier, this is where an applicant would go to access online applications. This section also contains information on licensure requirements, fees and other forms.

[Board Meeting Information](#)

This section includes meeting dates and locations, the actual agenda materials, minutes and audio of the meetings. You can also find information on the Board Members in this section.

[Contact Information](#)

This section provides the Board of Medicine address, telephone number, facsimile and email address.

[Continuing Education](#)

This section provides the continuing medical education requirements necessary for renewal of your license.

[Petitions for Declaratory Statements](#)

This section is a link to a searchable database of Final Orders on Petitions for Declaratory Statement. A Petition for Declaratory Statement is a legal mechanism for physicians to request clarification from the Board on a particular law as that law relates to that particular physician's circumstances.

[Practitioners Recovery Network \(PRN\)](#)

This section provides contact and other information for PRN, Florida's approved impairment program.

[Profession Updates](#)

This section contains alerts from the Department of Health, Board of Medicine and DEA. Also available in this section are the current and older versions of the *Messages from the Chair* and the Board's Annual Reports.

[Registration/Inspection](#)

This section has links to the Office Surgery Registration and Inspection Program and the Pain-Management Registration and Inspection Program. All information related to these two programs can be found here.

[Renewal](#)

This section provides renewal dates. You can also link to MQA Services where you renew your license. There is also information about renewing through the mail instead of online. Remember that renewing online is faster and you can print confirmation of your renewal.

[Laws and Rules](#)

This section of the web site lists all pertinent laws and rules as well as links to access them. There are a few specific laws highlighted in this section as well.

[Forms/Information](#)

This section houses all of our forms except applications for licensure. This includes the financial responsibility form; relinquishment forms; address change forms; dispensing practitioner registration forms; and many more. All forms can be completed online, printed and mailed to the Board Office.

A great option, for physicians to receive information as it occurs, is to join our Interested Parties List (Mailman). Emails will be sent directly to you with information we are posting on our web site. By using this tool, your email address is not readily available for public viewing on your Practitioner Profile. You can join the Mailman by clicking on its link on the Medicine web page or by going to http://www.doh.state.fl.us/mqa/medical/me_mailman.html.

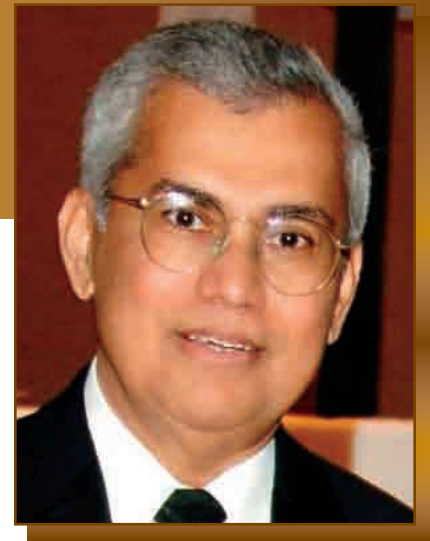
As always, if you cannot find the information you are looking for on our web site, we will be glad to assist you. You can send us an email at MQA_Medicine@doh.state.fl.us and we will respond within 24 hours.

Author: Crystal A. Sanford

Ms. Sanford is currently a Program Operations Administrator in the Board of Medicine and has worked in the Board for over 20 years.

MESSAGE *from the* CHAIR

by George Thomas, M.D.



George Thomas, MD, FACC
Chair, Florida Board of Medicine

FLORIDA BOARD OF MEDICINE DECEMBER 2011

Dear Doctors – The below Message from the Chair, Florida Board of Medicine, George Thomas, M.D., was emailed to those DCMA members we have email addresses for. We are reprinting in Miami Medicine for those of you who have not provided DCMA with a current email address. Please note that valuable information is emailed to DCMA members on a regular basis; please provide DCMA with your email address so you do not miss these important announcements. Email to phandler@miamimed.com, or fax your email address to the DCMA at 305 325-1316. Thank you. Patricia

Dear Colleagues and Fellow Citizens,

It is my great pleasure to bring you warm holiday greetings from the Board of Medicine, and give you another update on what every practicing physician needs to know. It appears to me that there is some apprehension in many physicians about the Board's work and changes in Florida Statutes. As mentioned before, our website is an excellent source of information, and below, I will summarize the key areas each physician should be familiar with.

1. You must update your practitioner profile within 15 days of any change.

You can do this by going online to <http://www.doh.state.fl.us/mqa/> and clicking on Practitioner Profile.

2. Do not pre-sign prescriptions. – This is a violation of the law.

3. You must keep charts on the family, friends, and employees that you treat.

Prescribing to your family members, friends and employees is not against the law. However, you are required to maintain medical records just like you would any other patient. You are not permitted to prescribe controlled substances to yourself under any circumstance.

4. Internet prescribing

Florida has a rule – [Rule 64B8-9.014, Florida Administrative Code](#) – that outlines acceptable telemedicine practice in Florida.

5. Patient Boundaries

The patient-physician relationship is built on mutual trust. Sexual misconduct in the practice of medicine is prohibited by law. The Board of Medicine has zero tolerance for sexual misconduct.

6. Relocate practice

There are steps you must follow when closing or relocating your office practice. You can find these steps in [Rule 64B8-10.002, Florida Administrative Code](#).

7. Help for Impaired practitioners

The [Professionals Resource Network \(PRN\)](#) is available to help physicians as well as applicants for licensure and medical students. PRN can be contacted at (800) 888-8776.

8. Pain-Management and Controlled Substances

There have been a lot of changes to pain-management in Florida.

- [Prescription Drug Monitoring Program \(E-Forcse\)](#) – in effect now

If you dispense controlled substances, you must register

May use to look up patient before prescribing

Register online at www.doh.state.fl.us/mqa

- Register by January 1, 2012 on your profile as a controlled substance

[prescriber](#) if you prescribe controlled substances for chronic nonmalignant pain [s. 456.44, FS]

- Must use [counterfeit proof prescriptions pads](#) from approved vendors for all controlled substance prescriptions
- No dispensing of Schedule II and III controlled substances
- New laws for pain-management clinics [s. 458.3265, FS]

9. At license renewal

- Florida physicians must renew their license every two years and can do it ONLINE at www.doh.state.fl.us/mqaservices
- To renew a Florida license, physicians are required to obtain the required CME, attest to financial responsibility coverage, and complete the [Physician Workforce Survey](#)
- Recent reduction of renewal fee to \$391 (includes background check fee and unlicensed activity fee)

10. CME requirements

You are required to complete 40 hours CME every two years. Of the 40 hours, two hours must be in the prevention of medical errors. Every six years, the 40 hours will include the two hours in the prevention of medical errors as well as a 2-hour course in domestic violence. Maintain your CME certificates for two licensing bienniums in case you are audited.

STAY IN TOUCH

Join our **Mailman System (Interested Parties List)**. It's a simple way to stay informed on changes in the laws and rules and updates from the Board. You will receive up to the minute information. To subscribe, log on to www.doh.state.fl.us/mqa/medical. Once there, follow these quick and easy steps:

- Click on *Interested Parties (Mailman)* in the blue box in the upper left-hand corner
- Enter your email address
- Click on *Subscribe*

I would like to congratulate Dr. Jason Rosenberg, Chair, Dr. Zach Zachariah, Vice-Chair and Dr. Nabil El Sanadi, First Vice-Chair for 2012. We are honored to have these talented individuals to the serve as Board's leadership.

Medicine is a profession that demands the best in us. There are close to 60,000 physicians holding active licenses from the State of Florida. Millions of Floridians depend, everyday, on your labor and commitment for their wellbeing. I would just like to remind each of you to be familiar with the laws and rules affecting your practice of medicine in Florida. The citizens of the Sunshine State need you, and on behalf of the Board, we truly appreciate your good work and dedication.

Have a Happy and safe holiday season,

George Thomas, MD, FACC
Chair, Florida Board of Medicine

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CME OPPORTUNITIES THROUGH BAPTIST HEALTH SOUTH FLORIDA

Baptist Health offers many other CME conferences at no charge. To obtain information about upcoming conferences, go to <http://baptisthealth.net/cme>. To request monthly mailings and symposium announcements, call Julie Zimmet, Medical Education, 786 596-2398 or e-mail cme@baptisthealth.net.

SECOND ANNUAL MIAMI ROBOTICS SYMPOSIUM
February 16 & 18, 2012
Fontainebleau Hotel, Miami Beach
Credits TBD

**CARDIOVASCULAR DISEASE PREVENTION 2012:
TENTH ANNUAL COMPREHENSIVE SYMPOSIUM**
February 23 – 26, 2012
Fontainebleau Hotel, Miami Beach
Credits TBD

ELEVENTH ANNUAL PRIMARY FOCUS SYMPOSIUM
June 22 – 24, 2012
Marco Island Marriott, Marco Island, Florida
Credits TBD



CME Calendar

Collaborative Institutional Training Initiative (CITI) Courses

(visit www.citiprogram.org for more information)

Basic Course in the Protection of Human Research Subjects

6 AMA PRA Category 1 Credits™
Credit available through June 30, 2013

Continuing Education Course (Refresher)

2 AMA PRA Category 1 Credits™
Credit available through June 30, 2013

Good Clinical Practices Course

4 AMA PRA Category 1 Credits™
Credit available through June 30, 2013

Health Information Privacy and Security Course

1.5 AMA PRA Category 1 Credits™
Credit available through June 30, 2013

Online Course

Medical Errors Prevention

2 AMA PRA Category 1 Credits™
Meets Florida Board of Medicine requirements
<http://cme.med.miami.edu/documents/medicalerrors.pdf>

SAVE THE DATE

March 1-2, 2012

**2nd Annual Therapeutic Hypothermia and
Temperature Management: Present & Future**
Mayfair Hotel, Miami, FL

March 15-17, 2012

7th Annual Perioperative Medicine Summit 2012
20.5 AMA PRA Category 1 Credits™
Eden Roc Hotel, Miami Beach, FL

March 30, 2012

Florida Ethics: Debates, Decisions, Solutions
Miami Beach Resort & Spa, Miami Beach, FL

April 21-22, 2012

**Dermatology "Close Up":
Melanoma and Other Neoplasms of the Skin**
The Alexander Hotel, Miami Beach, FL

To obtain information or to register for upcoming conferences, go to www.cme.med.miami.edu and click on "Conferences" or call University of Miami Miller School of Medicine, Division of Continuing Medical Education at 305- 243-6716 or email us at umcme@med.miami.edu.

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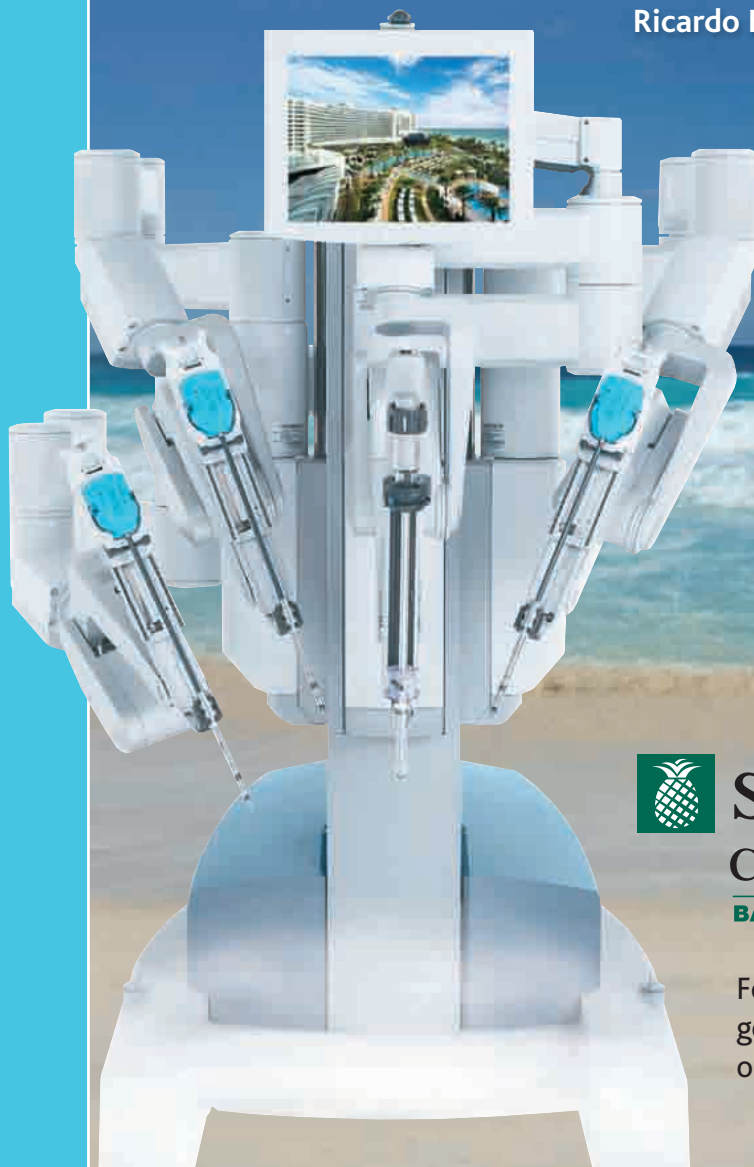
\$53.50 annually; single issue \$5.35

Second Annual Miami **Robotics** Symposium

**Thursday-Saturday
February 16-18, 2012**

Fontainebleau Hotel, Miami Beach, Florida

Ricardo E. Estape, M.D., Symposium Director



South Miami Hospital
Center for Robotic Surgery

BAPTIST HEALTH SOUTH FLORIDA

For symposium details and registration,
go to *MiamiRobotics.BaptistHealth.net*
or call 786-596-2398.

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