The Florida Medical Association Board of Governors recently released some bullet points on accountable care organizations. The new idea in “integrated healthcare delivery models” is now known as accountable care organizations (ACOs). Our State organization, the Florida Medical Association believes that the accountable care organizations should be “physician led with the best interest of patients in the forefront” as stated in a recent letter to membership by Dr. Madeline Butler, President of the Florida Medical Association. With physician leadership of these new alliances it is clear that medical decisions should be made and protected by physicians and that physicians stay involved in organization of these ACOs. Because these organizations are bound to be fraught with contractual matters, it is also recommended that legal review of any ACO contract, especially with a hospital is obtained. This means that seeking legal counsel opinion is important to ensure that your rights and the interests of your patients are protected according to a recent statement released by FMA general council Jeff Scott. The Florida Medical Association has also expressed their understanding of this developing process by adding more resources to assist members. There are 13 principles related to accountable care organizations:

1. Guiding principle - The goal of an accountable care organization is to increase access to care and improve the quality of care and ensure the efficient delivery of care. With an ACO, a physician’s primary ethical and professional obligation is the well being and safety of the patient.

2. ACO governance - ACOs must be physician led and encourage an environment of collaboration among physicians. ACOs must be physician led to ensure that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patient’s interests first.
   a. Decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians rather than lay entities and place patient’s interests first. Physicians are the medical professionals best qualified by training, education and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or the physician-controlled entity. The FMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensures that physicians control medical issues.
   b. The ACO should be governed by a Board of Directors that is elected by the ACO’s professionals. Any physician (e.g., independent physician association (IPA) medical group, etc.) that contracts with or is otherwise part of the ACO should be physician controlled and governed by an elected board of directors.
   c. The ACO’s physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO service area.
   d. Where a hospital is part of an ACO, the governing board of the ACO should be separate and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary - Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization including an organization that bills on behalf of physicians under a single tax identification number (or any other entity that creates an ACO must obtain the written confirmative consent of each physician to participate in the ACO). Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to the hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient services and distributed to the ACO patient participants.

5. With the flexibility in patient referral and antitrust laws the Federal and State anti-kickback and self referral laws and the Federal Civil Monetary Penalties Statute, (which prohibits payments by hospitals to physicians to reduce or eliminate care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospital or ACO. This is particularly important for physicians in small and medium sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties Statute, the anti-kickback statute and the ethics and patient referrals (Stark law).

Continued on page 2
PRESIDENT’S MESSAGE
Continued from page 1

The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the anti-trust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients and the anti-trust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up front in order to encourage ACO development. The CMS centers for Medicare and Medicaid innovation (CMI) should provide grants to physicians in order to finance upfront costs of creating an ACO. ACO incentives must be aligned with the physician or physician’s group risks (e.g., start up costs, system investments, culture changes and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo or small group practices requires time and resources and they all come as unknown. Providing additional resources for the upfront costs will encourage the development of ACOs since the “shared savings model” only provides for potential savings at the back end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACOs spending benchmarks should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
   a. The ACO spending benchmark, which will be based on historical spending patterns in the ACO service area and negotiated between Medicare and the ACO. They must be risk adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients such as the chronically ill.
   b. The ACO benchmark should be risk adjusted for the social, economic and health status of the patients who are assigned to each ACO such as income/poverty level, insurance status prior to Medicare enrollment, race and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
   c. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
   d. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient’s social, economic and health status factors.
   e. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary

should be provided in additional bonus payment. Any physicians in physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with FMA policy regarding quality. The ACO Quality Reporting Program must meet the FMA principles for quality reporting including the use of a nationally-accepted physician validating clinical measures developed by the FMA Specialty Society Quality Consortium. The inclusion of a number of patients to produce statistically valid quality information; appropriated attribution methodology, risk assessment and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary’s discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared savings program is limited to the traditional Medicare fee for service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods including fee for service, capitation, partial capitation, medical homes, care management fees and shared savings. Any capitation plan payments must be risk adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient satisfaction surveys should be used as a tool to determine patient satisfaction and whether an ACO meets the patient centeredness criteria required by the ACO law.

12. Interoperable health information technology and electronic health records systems are keys to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risks like a risk-bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

Sincerely yours and until next time,

Lance F. Grenevicki, MD, DDS, FACS
President, Brevard County Medical Society
UNDERSTANDING THE RISKS OF ADVERTISING

By the Risk Management Experts at First Professionals Insurance Company

Advertising is often heavily relied upon to acquire and maintain clientele. Healthcare advertisements are frequently used in much the same manner. From a liability standpoint, the fundamental risk management approach to physician advertising is that it be done in a legal and ethical manner. Consideration of rules and guidelines in your area of practice will ensure positive results from your advertising investment.

Due to the fact that advertisements in the healthcare profession are highly regulated, it is imperative that you consult federal, state, city and medical associations regarding rules, regulations and guidelines when creating advertisements for your medical practice. The form of the announcement should be easily comprehensible by the public. In some venues, any advertisement for free or discounted services must contain a specific statement regarding the patient’s rights. Content that by intent is educational could be interpreted by a court as a form of advertising and thus subject to the regulations pertaining to same. For these reasons, legal or risk management guidance should be obtained before advertisement content material is released for publication. Physician advertisements are generally considered to be false or misleading when containing:

- Misrepresentations of facts
- Only a partial disclosure of relevant facts
- False or unjustified expectation of the benefits of the services offered
- Representation or claims that cannot be met
- Representation, statements, or claims that mislead or deceives
- Statements or implications that a physician is a specialist unless formally recognized as such (and subject to individual state law)
- Misrepresentations of professional services and fees
- Failure to conspicuously identify the physician by name

The American Medical Association (AMA) states in its guideline E-5.02 Advertising and Publicity, that “there are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices”. The essential guiding standard is whether the advertising, regardless of format or content, is truthful and not materially misleading. Pursuant to the AMA, “objective claims regarding experience, competence, and the quality of the physicians and services they provide may be made only if they are factually supportable”.

Many health professionals are turning to the World Wide Web as a way of communicating to the public and allowing patients to access information more quickly. According to the AMA’s guideline E-5.027 Use of Health-Related Online Sites:

1. Contents on websites should be accurate, timely, reliable, and scientifically sound and referenced
2. Interactive sites should be consistent with general and specialty-specific standards
3. Participation in e-mail communicative interactive sites should follow AMA guideline E-5.026
4. Conflicts of interest shall be minimized
5. Security protections, privacy and confidentiality safeguards must be established, including patterns of use and interests.

In most jurisdictions, physicians will be personally held liable for the advertisement even when the content is prepared or circulated through an agent or third-party due to the fact that the medical professional has ultimate control over the substance of communication. It is the physician’s responsibility to review and ensure that advertisement material complies with applicable administrative rules or statutes governing the soliciting of patients. Noncompliance with rules and regulations could result in fines or potential actions against the physician’s license.

Risk Management Guidelines

- Adhere to AMA advertising guidelines(1) and local administrative rules
- Ensure that advertisements and brochures accurately reflect the services available
- Never guarantee or warranty results or outcomes
- Exercise caution with contracts or agreements with third parties that provide free or discounted services to your patients that could constitute “fee-splitting”
- Personally review the content of advertisements and brochures for accuracy
- Submit advertisement material to review by your personal attorney or insurance carrier
- Include the risks and complications with the benefits of a treatment or procedure
- Do not reinforce unrealistic expectations in photos or verbal statements
- Do not use language that will hold you to a higher, impossible to meet standard of care
- Confine advertisements to only those venues in which you are licensed to practice
- Indicate the states and jurisdictions where you are licensed to practice in advertisements in electronic modalities such as email, web page, television, and the internet
- Archive all advertisements – recording the dates placed in and out of circulation. These could become evidence in the event of litigation
- Retain video or audio tapes of advertising for at least a 90-day period from when last aired

(1)American Medical Association: Guideline E-5.027, Use of Health-Related Online Sites

For more information regarding this and other medical professional liability insurance risk management issues, please contact the risk management consultants at First Professionals Insurance Company at (800) 741-3742, ext. 3016 or send an e-mail to rm@fpic.com.

THE BULLETIN 3
Examination Response Clinic and Primary Access to Health Clinic from the National Association of County and City Health Officials.

Heidar Heshmati, M.D. was recognized by a resolution from Brevard County Board of County Commissioners on April 19, 2011 for the two Promising Practice Programs. The Sexual Assault Examination Response Clinic responds to sexual violence victims 24/7 with comprehensive, individualized, victim centered care in a safe location. Brevard County is the only health department in the state working in partnership with the State’s Attorney Office, Sexual Assault Victim Services, Salvation Army Domestic Violence Shelter to provide this unique program. The Primary Access to Health Clinic provides a medical home for the low income/underprivileged adult residents of Brevard County at no cost to the clients. Over 6000 services valued at $2.2 million were provided through this clinic. The Brevard County Health Department, Brevard County Board of County Commissioners, local hospitals and volunteer private providers contribute to the success of this program.

Influenza Treatment Guidelines 2011

Bruce Pierce, Community Health Services Director
Brevard County Health Department

The following guidelines are compiled from MMWR / January 21, 2011 / Vol 60 / No 1, Recommendations and Reports

Persons at high risk for influenza complications:

- Children aged <5 years (especially those aged <2 years)
- Adults ≥65 years
- Persons with chronic disease (except HTN: see article for details)
- Persons with immunosuppression
- Pregnant or postpartum women (within 2 weeks after delivery)
- Morbidly obese (i.e., BMI ≥40)
- Residents of long term care facilities

Brevard County Health Department received two “Promising Practices 2011” for the Sexual Assault

Continued on page 11
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ANIMAL RABIES</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BRUCELLOSIS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAMPYLOBACTERIOSIS</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>CIGUATERA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CREUTZFELDT-JAKOB DISEASE (CJD)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CRYPTOSPORIDIOSIALS</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>CYCLOSPOROSIS</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>ESCHERICHIA COLI 0157:H7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ESCHERICHIA COLI, SHIGA TOXIN PRODUCING</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>GARDIASS</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>H. INFLUENZAE MENINGITIS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HAEMOPHILUS INFLUENZAE (INVASIVE DISEASE)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HEPATITIS A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>HEPATITIS B (+HbsAg IN PREG WOMEN)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>HEPATITIS B, ACUTE</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>HEPATITIS B, CHRONIC</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>HEPATITIS C, CHRONIC</td>
<td>210</td>
<td>108</td>
</tr>
<tr>
<td>INFLUENZA A, NOVEL OR PANDEMIC STRAINS</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>LEAD POISONING</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>LEGIONNAIRE’S DISEASE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LEPROSY (HANSEN’S DISEASE)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>LISTERIOSIS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LYME DISEASE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MALARIA</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>MENINGITIS, BACTERIAL CRYPTOCCAL, MYCOTIC</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MENINGITIS, STREPTOCOCCUS PNEU</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MENINGOCOCCAL DISEASE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PERTUSSIS</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>SALMONELLOSIS</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>SHIGELLOSIS</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>STREPTOCOCCUS PNEU DRUG RESISTANT</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>STREPTOCOCCUS PNEU, INVASIVE DISEASE, SUSCEPT</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>STREPTOCOCCAL DISEASE INVAS GROUP A</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>TYPHOID FEVER</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VARICELLA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO ALGINOLYTICUS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO CHOLERAES NON-01</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO FLUVALIS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO MIMICUS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO PARAHAELOMYCITIC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO VULNIFICUS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VIBRIO, OTHER</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Cases of AIDS should be reported to:
Diane Franta
AIDS Surveillance
Brevard County Health Department — 690-6485

Cases of Sexual Trasmitted Diseases should be reported to:
STD OFFICE
Brevard County Health Department — 690-6489

All other Communicable Diseases should be reported to:
EPIDEMIOLOGY DEPARTMENT
Brevard County Health Department – 454-7101

“**The best executive is the one who has sense enough to pick good men to do what he wants done, and self-restraint enough to keep from meddling with them while they do it.**”

– Theodore Roosevelt

**MANDATORY REPORTING MEDICARE SECONDARY PAYER ACT**
Continued from page 7

Information detailing any resolution or settlement of a claim, with a focus on explaining whether the claim was contested or not, and whether the primary payer has assumed ongoing responsibility for medical costs associated with the claim.

There are very steep fines ($1,000 per day, per claimant) for failure to report pursuant to these requirements.

The reporting requirement does not apply to Medicaid recipients.

Contact CMS at [http://www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep) or by phone at 800-999-1118. Additional information may also be obtained by contacting the First Professionals Risk Management Department at 800-741-3742 ext. 3016 or via e-mail to rm@fpic.com.
The Center for Medicare and Medicaid Services ("CMS") recently issued an alert ("Alert") revising the timeline for liability carriers reporting Medicare settlements or judgments.

Effective April 1, 2011 (rather than January 1, 2010), the Medicare Secondary Payer Act [42 U.S.C. 1395y(b)(7) & (8)] requires that all liability carriers report payments made to any Medicare plaintiff/claimant to the CMS. This reporting requirement may also apply to payments made directly by a physician and by "self-insured" physicians.

First Professionals Insurance Company will report payments made on behalf of its policyholders to CMS. For payments made by a physician directly to a claimant, the physician may be responsible for reporting to CMS. See reporting information below.

Reports must be submitted to CMS in electronic format only, on the CMS website: http://www.com.hhs.gov/MandatoryInsRep. However, the electronic reporting may be waived when there is no method available for the submission of claims (a) in an electronic format; (b) for a provider of services with fewer than 25 full-time equivalent employees; or (c) for a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

EXTENSION FOR REPORTING:
Liability insurance (including self-insurance) total payment obligations to claimant ("TPOC") must be reported if the settlement date is on or after October 1, 2011 (rather than October 1, 2010). The reporting must be no later than the designated submission window in the first quarter of 2012.

The Alert states that the reporting entity has the option to report liability (including self-insurance) TPOC settlements prior to the first quarter of 2012. The reporting entity must report during their assigned quarterly submission window.

EXTENSION OF CURRENT DOLLAR THRESHOLDS:
The Alert provides for the interim dollar reporting thresholds, to be extended by one year. The thresholds for exemption from reporting are summarized as:
- Settlement date prior to January 1, 2013 and amount is $5,000 or less
- Settlement date during 2013 and amount is $2,000 or less
- Settlement date during 2014 and amount is $600 or less

CMS will assign each registered liability carrier a specific date for reporting every quarter. If a physician makes a payment directly to a plaintiff/claimant which meets the reportable threshold, CMS should be contacted as soon as possible regarding how and what to report. Generally, the report date is determined by the date of settlement, date of verdict, or date of appeal result, not the date that payment is made.

Factors to consider in determining whether you must report a payment:
1. Is the plaintiff/claimant a Medicare recipient?
   Look at the entitlement at the "time of incident":
   - Persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement Benefits;
   - Disabled persons (totally disabled) receiving SSDI;
   - Persons of any age who have received Social Security, widows or Railroad Disability Benefits for 25 months (this may apply to disabled minors/adults);
   - Persons with end-stage renal disease who require dialysis treatment or kidney transplant; and
   - Working persons over age 65 that are not eligible for either Social Security or Railroad Retirement Benefits who purchase Medicare coverage by monthly payment or as active employees for an employer of 20 or more employees.
2. Is the payment over the dollar threshold for the year it was made?
   If you must report, how and what do you report?
   Generally, unless a waiver is received for electronic reporting, every report must contain the following information for each claimant:
   - Name of claimant (with middle initial);
   - Social Security number (HICN when available);
   - Complete address;
   - Telephone number;
   - Gender;
   - Date of birth;
   - Date of death, if applicable;
   - Full contact information on any estates, siblings or other representative claimants, if applicable;
   - Full contact information for claimant’s attorney including tax ID numbers, if applicable;
   - Dates and the nature of any injuries, including whether the injury involved an allegedly defective product, if applicable;

   Continued on page 5
ENFORCEABILITY OF PHYSICIAN NONCOMPETE CLAUSES

Does 10 miles make a difference in a noncompete clause? A court in Lee County, Florida, is about to answer this question. Dr. Eric Eskioglu alleges that the 2006 noncompete clause in his employment contract with Lee Memorial Health System is unenforceable. The contract restricts Dr. Eskioglu from practicing neurosurgery within 50-miles of Lee Memorial Hospital. Dr. Eskioglu has resigned from Lee Memorial Health System and has started performing neurosurgery at Physicians’ Regional Medical Center in Collier County, 40 miles away. The impending question is whether the court should enjoin him from continuing to perform surgeries at Physicians Regional. Unique to his case is the fact that Dr. Eskioglu’s practice involves a new type of minimally invasive neurosurgery that only approximately 60 physicians in the Country are trained to perform. Thus, the jury will have to decide if Dr. Eskioglu’s unique skills benefit the community enough to modify the terms of his employment contract. See Eskioglu v. Lee Memorial Health System, 11-CA-000617(12th Judicial Circuit, J. McHugh).

While this case is interesting for its public policy precedent, the more pressing question for most employers and physicians are: what are your rights as an employer who has a noncompete clause with an employed physician; or as an employed physician what are your legal obligations under a noncompete clause and what defenses might be available to you.

Since noncompete clauses are generally governed by the law in effect as of the year they were entered, a short overview of the history and evolution of noncompete clauses is informative to these questions. Florida has a somewhat tortured history when it comes to interpreting and enforcing post-termination restrictive covenants (frequently termed noncompete clauses) in employment contracts as discussed herein.


However, the 1970’s and 1980’s Florida courts veered away from the original intent of the legislation and instead sunk into the murky abyss of contract case law. Thus, decisions were inconsistent, fact oriented and extremely unpredictable. The thread of consistency that emerged through the case law was a judicially created presumption of irreparable harm where a breach of the noncompete clause was shown. This allowed the entire body of noncompete clause judicial interpretation to be focused on whether the noncompete clause was reasonable. That question in turn typically centered around the geographic scope and term of the limitation. See King v. Jessup, 698 So. 2d 339 (Fla. 5th Dist. Ct. App. 1997)(acknowledging the judicial creation of presumption of irreparable harm); See also infra (Grant & Steele; Sanchez)

In 1990, there was a significant amendment to Section 542.33, enacted by the Florida Legislature which eliminated the judicially created presumption of irreparable harm and instead forced the employer to prove that the breach of the noncompete clause actually caused the employer irreparable harm. Obviously, this made it much more difficult for employers to enforce noncompete clauses. In 1996, however, the Florida Legislature adopted Section 542.335, which among other changes shifted the burden of proof of irreparable harm from the employer having to prove there was irreparable harm to the employee having to prove there was not irreparable harm. See Infra Grant & Steele; Sanchez. Thus, depending on when the noncompete clause was entered into there could be vastly different results as to its enforceability.

Regardless of when a noncompete clause was entered, there are numerous defenses that both employers and employees should understand. The first issue to consider is the duration of the restrictive covenant. Section 542.335 Florida Statutes creates specific “rebuttable presumptions” for restrictions against former employees and those that are 6 months or less are presumed reasonable and enforceable, while those over 2 years are presumed not reasonable and not enforceable. The substantial grey area in between 6 months and 2 year must be weighed and evaluated based on all of the facts and circumstances.

As to geographic scope, the statute does not create a specific range of reasonable scope, but generally speaking the larger the scope, the less likely of its enforceability. On the other hand, the more specialized area that the physician practices, the greater geographic area that might be determined to be reasonable. An important consideration in this determination are the available alternatives for patients within the particular geographic area to access the same physician services. Thus, in the Eskioglu case, the fact that Dr. Eskioglu has a specialized medical practice will weigh in favor of allowing a broad geographic range to be acceptable for his noncompete clause; however, the fact that there are so few neurologists that have his skill set and the potential harm to patients that have to travel to receive those services will weigh in favor of finding the noncompete clause unenforceable as a matter of public policy.

Continued on page 10
ELECTRONIC REMITTANCE ADVICE, YOU, AND YOUR VENDOR/CLEARINGHOUSE

Do you think you are ineligible for electronic remittance advice (ERA) since you submit claims through a vendor/clearinghouse? Think again.

By: First Coast Service Options, Inc.

Even if you contract with a vendor or clearinghouse, you may still be eligible to receive the electronic remittance advice. In addition, if your vendor or clearinghouse is still receiving standard paper remittance (SPR) they may be eligible for ERA as well.

First Coast Service Options (FCSO) understands that each provider’s billing situation may be different. However, the vast benefits of ERA are worth the time and effort of researching and determining if it is a possibility for your situation.

What are the benefits of ERA?

Using the ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. The ERA can be exchanged between partners with much greater ease than a paper remittance.

Advantages to using the ERA include:

• Faster communication and payment notification;
• Faster account reconciliation through electronic posting;
• Less paper generated;
• Lower operating costs;
• More detailed information; and
• Free software.

Contact the Electronic Data Interchange (EDI) department at FCSO for further information on your situation and the availability of ERA for your office.

To assist in the transition from SPR to ERA, FCSO will allow you to receive both (SPR and ERA) for a period of time. This will ensure there are no interruptions in posting of payments for processed claims during the transition period. You or your vendor/clearinghouse would have the SPR to rely on until it is confirmed that your retrieval and printing of the ERA is working properly.

The Centers for Medicare & Medicaid Services (CMS) even offers free software for Part A and Part B providers for use in viewing and printing duplicate copies of ERA whenever you wish. If you currently submit your claim electronically and are not set up for electronic remittance, please complete the electronic data request form found at http://medicare.fcso.com/EDI_forms/138245.pdf prior to downloading the free software.

If you or your vendor/clearinghouse is eligible, how do you get the free software?

• For Part A providers, download PC-Print Software found at http://medicare.fcso.com/PC-print_software/.
• For Part B providers, download MREP Software found at http://medicare.fcso.com/MREP/.

A few minutes of research now may save you time and frustration later.

BCMS WELCOMES OUR CIRCLE OF FRIENDS PARTNERS

PNC Healthcare Business Banking — For more information call Bruce Reeder, Vice President, Business Banker, 321.549.3825 or Mike Estes, Vice President, Healthcare Business Banker, 407.508.9203.

Maderi Caretenders – Visit www.almostfamily.com or call Colleen Layton, RN, BSN, Executive Director, 321.308.0321.


The Brevard County Medical Society (BCMS) established the Circle of Friends program to invite businesses serving physicians and their staff to increase visibility among our members.

What are the benefits?

• Ability to connect with almost 300 Brevard County physicians and highlight your products and services as a preferred partner
• Potential inclusion in marketing and advertising support provided by SCB marketing, publishers of Spacecoast Living and Spacecoast Business
• Opportunity to extend special services to BCMS membership
• Year-round name recognition in BCMS Circle of friends listing in the BCMS member newsletter, The Bulletin, published three times annually
• Listing on BCMS website, including company description, contact information and link to your website
• Recognition on BCMS Circle of friends poster on display at events
• Exclusive announcement to BCMS members when you join BCMS Circle of Friends or renew your membership, including detailed company information and contact information
• First choice for event sponsor opportunities

Contact Linda at the BCMS office, exec@brevardcms.org or by calling 632.8481 for information about the program.
**MEDICARE REMIT EASY PRINT (MREP)**

Information on the free software for viewing and printing electronic remittance advice (ERA)

By: First Coast Service Options, Inc.

First Coast Service Options Inc. (FCSO) wants to make your job as a Medicare Part B provider as easy as possible. MREP is free software that the Centers for Medicare & Medicaid Services (CMS) has made available for Part B providers that sign up for ERA. You can find this MREP software on the FCSO Medicare provider website. This software enables you to view and print ERA by importing health insurance portability and accountability act (HIPAA) 835 files received from FCSO. After importing the files, you may print the ERA in a format similar to standard paper remittance (SPR) or view it on screen, directly through the MREP software.

**You can view the information several ways using the MREP software, including:**

- Entire remittance report - ERA format similar to the SPR
- Tabbed information view - Six tabs to choose from to narrow the ERA information to only what is needed by the provider
- Special reports – Five reports to choose from to obtain specific ERA information


Access [www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp](http://www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp) to find the Medicare Remit Easy Print User Guide for additional information on how to install and access the software.

Please complete the electronic data request form at [http://medicare.fcso.com/EDI_forms/138245.pdf](http://medicare.fcso.com/EDI_forms/138245.pdf) prior to downloading the free software if you currently submit your claims electronically but are not set up for electronic remittance advice.

**How do you get the free software?**


After reviewing the guides, if you still need assistance with signing up for ERA and using the software, contact FCSO’s electronic data interchange (EDI) department at (888) 670-0940.

---

**PC-PRINT**

Information on the free software for viewing and printing electronic remittance advice (ERA)

By: First Coast Service Options, Inc.

First Coast Service Options Inc. (FCSO) wants to make your job as a Medicare Part A facility as easy as possible. PC-Print is free software that the Centers for Medicare & Medicaid Services (CMS) has made available for Part A providers that sign up for ERA. You can find this software on the FCSO Medicare provider website. This software enables you to view and print ERA by importing health insurance portability and accountability act (HIPAA) 835 files received from FCSO. After importing the files, you may print the ERA in a format similar to standard paper remittance (SPR) or view it on-screen, directly through the PC-Print software.

**You can view the information several ways using the PC-Print software, which is designed to produce one of four print versions of data contained in an 835, including:**

- Option 1: The all claims (AC) screen, which displays 835 data in a manner similar to the format and content of a standard paper remit (SPR).
- Option 2: The single claim (SC) screen, which provides a detailed summary of data from a single claim.
- Option 3: The bill type summary (SB) screen, which provides a summary of claims billed for each type of bill (TOB), for each provider number, and for each fiscal year (FY).
- Option 4: The provider payment summary (PS) screen, which provides a summary of the provider’s payments from this ERA, regardless of the TOB or fiscal year end (FYE).


Access [www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp](http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp) to find the Medicare Remit Easy Print User Guide for additional information on how to install and access the software.

Please complete the electronic data request form at [http://medicare.fcso.com/EDI_forms/138245.pdf](http://medicare.fcso.com/EDI_forms/138245.pdf) prior to downloading the free software if you currently submit your claims electronically but are not set up for electronic remittance advice.

**How do you get the free software?**


After reviewing the guides, if you still need assistance with signing up for ERA and using the software, contact FCSO’s electronic data interchange (EDI) department at (888) 670-0940.
ENFORCEABILITY OF PHYSICIAN NONCOMPETE CLAUSES
Continued from page 7

One of the most common defenses to the enforceability of a noncompete clause is that the employer breached the underlying employment contract (a prior breach of a dependent covenant) and therefore the employee’s obligations under the noncompete are not enforceable because of the employer’s breach. On a related concept, an employee may also claim the employer has “unclean hands” and therefore the noncompete clause is unenforceable. For example, if an employer was asking the employed physician to do something unethical or illegal, it could be argued the employer does not have “clean hands” to enforce the noncompete clause. Another common defenses to a noncompete clause is that the employer failed to enforce a similar noncompete clause against other employees and has waived the right to enforce it now. See N. James Turner, Successfully Defending Employees in Noncompete and Trade Secret Litigation, 78 FLA. B.J. 43, 44-46 (2004); See, e.g., Cordis Corp. v. Prooslin, 482 So. 2d 486 (Fla. 3d DCA 1986)(denied temporary injunction where employer breached underlying contract); Benemeroit & Flores, M.D.s, P.A. v. Roche, 751 So. 2d 91 (4th DCA 1999) (noncompete clause unenforceable where employer breached the employment contract by failing to fully compensate her for services provided); Trup v. Heacock, 367 So. 2d 691 (Fla. 1st DCA 1979)(same); Bradley v. Health Coalition, Inc., 687 So. 2d 329 (3d DCA 1997)(same); Bradley v. Health Coalition, 687 So. 2d 329 (3d DCA 1997)(holding employer had “unclean hands” and could not enforce noncompete agreement where employer had attempted to make employee resell certain plasma products that had been returned by a customer and employee believed product had been rendered unsafe for medical use).

There are also of course other basic contract defenses such as lack of consideration or statute of frauds problems. For example, where the written contract has ended per its terms but an oral extension of the employment contract is entered into and both parties continued to work under similar terms without executing a new written employment contract, most courts have held that the failure to have a written noncompete clause makes enforceability of the employment contract term based on the prior written agreement unenforceable. See Sanz v. R.T. Aerospace Corp. 650 So. 2d 1057 (Fla. 3d Dist. Ct. App. 1995) (holding employee not bound by noncompete where contract was orally extended after three year term had expired); Gray v. Prime Management Group, Inc., 912 So. 2d 711 (Fla. 4th Dist. Ct. App. 2005)(holding oral extension of employment contract did not apply to his non-compete agreement); Zupnik v. All Florida Paper, Inc., 997 So. 2d 1234 (Fla. 3d Dist. Ct. App. 2008)(holding “post-termination restrictions expire upon the termination of [a contract] for a specific term, even if [the] employee remains an at-will employee after the [contract term ends].”)

Another issue is whether particular interests of an employer may even be protected as a “legitimate business interest.” For example, there is wide spread agreement in Florida courts that a general advertisement seeking new patients usually will not be considered a violation of a physician noncompete because it is not a solicitation aimed at specific current or prospective patients of the former employer.

On the other hand, there is disagreement in Florida courts as to whether a former employee violates a noncompete by seeking patient referrals from “referring physicians.” Some courts have ruled that there is no violation in seeking referrals from the former employer’s “referring physicians;” while other Courts have ruled that there is a legitimate and enforceable business interest in protecting established relationships with “referring physicians.”

Another potential defense and issue involves consideration of public policy and the relationship between patients and physicians. Florida law specifically recognizes that restrictive covenants among lawyers will be narrowly construed to protect the “special trust and confidence” inherent in attorney-client relationships. Some legal commentators have called for a similar approach as to restrictive covenants involving physician-patient relationships. See Infra Sanchez. While courts in Florida have thus far rejected some broad based attacks on restrictive covenants for physicians as being “void and against public policy” other states have found that the physician-patient relationship is entitled to the same degree of protection as the lawyer-client relationship, and therefore noncompete clauses are narrowly construed with special consideration of possible negative impacts on the public.

All and all there are numerous defenses to enforceability of noncompete clauses. Whether you are the employer seeking to draft an enforceable noncompete agreement, or an employee about to enter into a contract with a noncompete clause, or even a party to a contract that has a noncompete clause, given the uncertainty and inconsistency of the courts in this rapidly evolving field of law, it is always best to seek advise of legal counsel on the specific issues as they relate to your contract. When consulting legal counsel about the noncompete clause make sure to ask about liquidated damages provisions and their enforceability and also about potential tortuous interference of a contractual relationship claims and possible attorneys’ fees consequences to the non-prevailing party, as all of these issues are inextricably involved in every noncompete clause. ✤

Susan C. Smith is a partner with Smith & Associates. She was admitted to the Florida Bar in 1999, after graduating as Valedictorian from Stetson University, College of Law. She served as a Law Clerk for Justice Peggy A. Quince at the Florida Supreme Court before entering the private practice of law. She has over ten years of attorney experience in administrative law, health care law, and civil litigation. Susan is currently an “AV” rated attorney by Martindale-Hubbell. Her key practice areas include: Administrative Law; Health Care Law; Hospital and Facility Licensing and Regulation; Medicare and Medicaid Certification and Regulation; Professional Licensing and Disciplinary Proceedings; Bid Protests; Complex Litigation; Appeals and Appellate Law; Starke Law; Medicaid/Medicare Fraud and Abuse Law; Federal EMTALA; Florida Access to Emergency Medicine; Mergers and Acquisitions; Change in Ownership (CHOW) proceedings

DID YOU KNOW?
That The Bulletin is supported in part by the advertising on its pages?
Try asking your vendors to advertise with us!
That’s a win-win situation!
Call 632-8481
Annual influenza vaccination remains the most effective method for preventing influenza infection and its complications.

Recommendations for the use of antiretrovirals

1. Treat as soon as possible those with confirmed or suspected influenza who have severe, complicated, progressive illness or those requiring hospitalization.

2. Outpatients as soon as possible with confirmed or suspected influenza who are at higher risk for influenza complications based on age or underlying medical conditions.

3. Use oseltamivir and zanamivir. Should not use amantadine or rimantadine.

4. Oseltamivir may be used for treatment or chemoprophylaxis of influenza among infants aged <1 year.

5. Antiviral treatment may be considered for any outpatient with confirmed or suspected influenza, with no known risk factors, if treatment can be initiated within 48 hours of illness onset.

6. Monitor local antiviral resistance surveillance data.

<table>
<thead>
<tr>
<th>TABLE 1. Recommended dosage and schedule of influenza antiviral medications* for treatment† and chemoprophylaxis§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiviral agent</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Zanamivir</strong></td>
</tr>
<tr>
<td>Chemoprophylaxis, influenza A and B</td>
</tr>
<tr>
<td><strong>Oseltamivir</strong>†</td>
</tr>
<tr>
<td>Chemoprophylaxis, influenza A and B</td>
</tr>
</tbody>
</table>

Abbreviation: NA = not approved.

* Zanamivir is manufactured by GlaxoSmithKline (Relenza — inhaled powder). Zanamivir is approved for treatment of persons aged ≥7 years and approved for chemoprophylaxis of persons aged ≥5 years. Zanamivir is administered through oral inhalation by using a plastic device included in the medication package. Patients will benefit from instruction and demonstration of the correct use of the device. Zanamivir is not recommended for those persons with underlying airway disease. Oseltamivir is manufactured by Roche Pharmaceuticals (Tamiflu — tablet). Oseltamivir is available for oral administration in 30 mg, 45 mg, and 75 mg capsules and liquid suspension. No antiviral medications are approved for treatment or chemoprophylaxis of influenza among children aged <1 year. This information is based on data published by the Food and Drug Administration (FDA), available at http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm100228.htm.

† Recommended duration for antiviral treatment is 5 days. Longer treatment courses can be considered for patients who remain severely ill after 5 days of treatment.

‡ Recommended duration is 10 days when administered after a household exposure and 7 days after the most recent known exposure in other situations. For control of outbreaks in long-term care facilities and hospitals, CDC recommends antiviral chemoprophylaxis for a minimum of 2 weeks and up to 1 week after the most recent known case was identified.

§ See Table 4 for information about use of oseltamivir for infants aged <1 year. A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance <30 mL/min.

** The treatment dosing recommendation for oseltamivir for children aged ≥1 year who weigh ≤15 kg is 30 mg twice a day. For children who weigh >15 kg and up to 23 kg, the dose is 45 mg twice a day. For children who weigh >23 kg and up to 40 kg, the dose is 60 mg twice a day. For children who weigh >40 kg, the dose is 75 mg twice a day.

†† The treatment dosing recommendation for oseltamivir for children aged ≥1 year who weigh ≤15 kg is 30 mg once a day. For children who weigh >15 kg and up to 23 kg, the dose is 45 mg once a day. For children who weigh >23 kg and up to 40 kg, the dose is 60 mg once a day. For children who weigh >40 kg, the dose is 75 mg once a day.
IN A MEDICAL MALPRACTICE CLAIM:
Be ready for anything and everything.

Decades of experience, true financial stability, and a tough-as-nails defense team make First Professionals a well-rounded — and yes, affordable — choice when it comes to protecting your medical reputation and career. No other Florida medical malpractice provider knows the industry quite like we do, nor do they defend our doctors with as much tenacity. We’re committed to protecting you and everything you’ve got, with everything we’ve got.

For more information, contact Shelly Hakes, Director of Society Relations at (800) 741-3742, Ext. 3294.

www.firstprofessionals.com

BREVARD COUNTY MEDICAL SOCIETY
P.O. Box 560675
Rockledge, FL 32956-0675

Change Service Requested