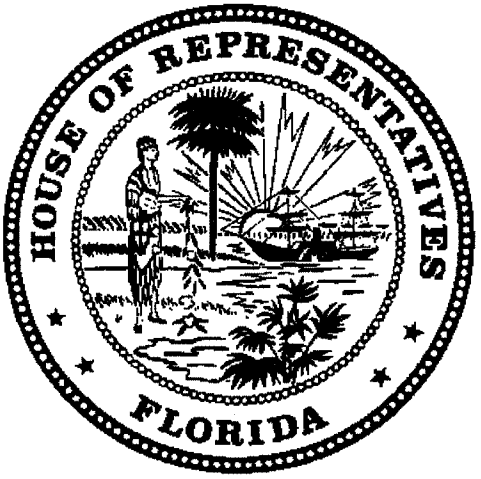


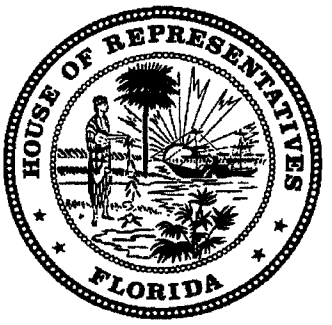
Health Care Appropriations Subcommittee

Meeting Packet

April 8, 2011
8:45 AM—10:45 AM
Webster Hall

Dean Cannon
Speaker

Matt Hudson
Chair



AGENDA
Health Care Appropriations Subcommittee
April 8, 2011
8:45 a.m. – 10:45 a.m.
Webster Hall

I. Call to Order/Roll Call

II. Opening Remarks

III. HB 909—Emergency Medical Services by Perry

IV. CS/HB 959—Administrative, Licensure, and Programmatic Monitoring of Mental Health and Substance Abuse Service Providers by Young

V. CS/HB 1319 Temporary Certificates and Licenses for Certain Health Care Practitioners by Harrell

VI. CS/CS/HB 479—Medical Malpractice by Horner

VII. Closing Remarks/Adjournment

HB 909
Perry

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 909 Emergency Medical Services
SPONSOR(S): Perry and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1358

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Access Subcommittee	14 Y, 0 N	Holt	Schoolfield
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2009, the U.S. Department of Transportation released the new National Emergency Medical Services (EMS) Education Standards for emergency medical technicians (EMTs) and paramedics. The bill updates Florida's EMTs and paramedics training requirements to reflect the new 2009 national training standards.

The bill amends the definition of "basic life support" to update the definition to include the name of the new National EMS Education Standards, removes outdated competencies that are captured within the training course and makes conforming changes. The bill increases the timeframe that EMT or paramedic can take the state examination following successful completion of an approved training program from 1 to 2 years.

The bill removes the requirement that EMTs and paramedics complete the requirement for HIV/AIDS continuing education instruction. The bill amends the timeline that the state emergency medical services plan is updated from biennially to every five years.

The bill has no fiscal impact on the state or local governments.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background
Emergency Medical Technicians and Paramedics

The Department of Health (DOH), Division of Emergency Operations regulates emergency medical technicians (EMTs) and paramedics. EMTs and paramedics are regulated pursuant to ch. 401, Part III, F.S. As of June 30, 2010, there were 35,828 active in-state licensed EMTs and 24,103 active in-state licensed paramedics in Florida.[1]

HIV and AIDS Training Requirements

In 2006, the Legislature revised the requirements for HIV/AIDS continuing education instruction in the general licensing provisions for health practitioners[2] regulated by s. 456.033, F.S.[3] The law removed the requirement that the HIV/AIDS continuing education course be completed at each biennial license renewal. Instead, licensees are required to submit confirmation that he or she has completed a course in HIV/AIDS instruction at the time of the first licensure renewal or recertification.[4]

Section 381.0034, F.S., requires the following practitioner groups to complete an HIV/AIDS educational course at the time of biennial licensure renewal or recertification:

- EMTs and paramedics;
- Midwives;
- Radiologic personnel and
- Laboratory personnel.

Failure to complete the HIV/AIDS continuing education requirement is grounds for disciplinary action.[5]

National EMS Education Standards

In 2009, the U.S. Department of Transportation released the new National Emergency Medical Services (EMS) Education Standards (Standards), which replaces the National Highway Traffic Safety Administration, National Standard Curricula (or Emergency Medical Technician-Basic Standard Curriculum) at all licensure levels.[6]

The Standards define the minimal entry-level educational competencies, clinical behaviors, and judgments that must be met by EMS personnel to meet national practice guidelines.[7] The Standards provide guidance to instructors, regulators, and publishers regarding the content to provide interim support as EMS instructors and programs across the nation transition from the National Standard Curricula to the National EMS Education Standards.

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[1] Florida Department of Health, Division of Medical Quality Assurance, Annual Report: July 1, 2009-June 30, 2010, *available* at: http://www.doh.state.fl.us/mqa/reports.htm (last viewed March 20, 2011).
[2] Acupuncturist; physician; osteopathic physician; chiropractic physician; podiatric physician; certified optometrist; advanced registered nurse practitioner; registered nurse; clinical nurse specialist; pharmacist; dentist; nursing home administrator; occupational therapist; respiratory therapist; or nutritionist; or physical therapists.
[3] *See* 2006-251, L.O.F.
[4] s. 456.033, F.S.
[5] s. 381.0034(2), F.S.
[6] National Highway Traffic Safety Administration, Emergency Medical Services, Educational Standards and NSC: National Emergency Medical Services Education Standards, *available* at:http://www.ems.gov/education/nationalstandardandncs.html (last viewed March 20, 2011).
[7] *Id.*

The Standards assume there is a progression in practice from the entry-level Emergency Medical Responder level to the advanced Paramedic level.[8] That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level.[9] According to the Standards, there are four licensure levels of EMS personnel: Emergency Medical Responder; Emergency Medical Technician; Advanced Emergency Medical Technician; and Paramedic.[10] For example, a Paramedic is responsible for knowing and doing everything identified in that specific area, as well as knowing and doing all tasks in the three preceding levels. Essential components of the EMS National agenda included creating a single National EMS Accreditation Agency and a single National EMS Certification Agency to ensure consistency and quality of EMS personnel.[11]

Emergency Medical Services State Plan

Currently, the DOH is responsible for the improvement and regulation of basic and advanced life support programs and is required to biennially develop and revise a comprehensive state plan for basic and advanced life support services.[12]

The Effects of the Bill

The bill removes the requirement that EMTs and paramedics complete the requirement for HIV/AIDS continuing education instruction. Universal precautions[13] are core concepts of the EMT and paramedic training and are practiced in the field daily, therefore are an unnecessary continuing education requirement.[14]

The bill amends the definition of "basic life support" to update the definition to include the name of the new National EMS Education Standards and removes outdated competencies that are captured within the training curriculum. The bill makes conforming changes by removing "emergency medical technician basic training course" and adding "National EMS Education Standards," which aligns with the most current national standard. The bill also increases the timeframe that EMT or paramedic can take the state examination following successful completion of an approved training program from 1 to 2 years.

The bill amends the timeline that the state emergency medical services plan is updated from biennially to every five years.

B. SECTION DIRECTORY:

Section 1. Amends s. 381.0034, F.S., relating to the requirements for instruction on HIV and AIDS.

Section 2. Amends s. 401.23, F.S., relating to definitions.

Section 3. Amends s. 401.24, F.S., relating to emergency medical services state plan.

Section 4. Amends s. 401.27, F.S., relating to personnel standards and certification.

Section 5. Amends s. 401.2701, F.S., relating to emergency medical services training programs.

Section 6. Provides an effective date of July 1, 2011.

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[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] U.S. Department of Transportation, National Emergency Medical Services Education Standards, available at: http://www.ems.gov/education/nationalstandardandncs.html (last viewed March 20, 2011),
[12] s. 401.24, F.S.
[13] Under universal precautions all patients were considered to be possible carriers of blood-borne pathogens to include HIV/AIDS.
[14] Per telephone conversation with DOH, Division of Emergency Operations staff (March 2011).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None identified at this time.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The department has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to emergency medical services; amending s. 381.0034, F.S.; deleting the requirement for emergency medical technicians and paramedics to complete an educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome; amending s. 401.23, F.S.; redefining the term "basic life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act; amending s. 401.24, F.S.; revising the period for review of the comprehensive state plan for emergency medical services and programs; amending s. 401.27, F.S.; revising the requirements for certification or recertification as an emergency medical technician or paramedic; revising the requirements for certification for an out-of-state trained emergency medical technician or paramedic; amending s. 401.2701, F.S.; revising requirements for an institution that conducts an approved program for the education of emergency medical technicians and paramedics; revising the requirements that students must meet in order to receive a certificate of completion from an approved program; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(1) As of July 1, 1991, the Department of Health shall require each person licensed or certified under ~~chapter 401,~~ chapter 467, part IV of chapter 468, or chapter 483, as a condition of biennial relicensure, to complete an educational course approved by the department on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current state ~~Florida~~ law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients. Each such licensee or certificateholder shall submit confirmation of having completed the ~~said~~ course, on a form provided by the department, when submitting fees or application for each biennial renewal.

Section 2. Subsection (7) of section 401.23, Florida Statutes, is amended to read:

401.23 Definitions.—As used in this part, the term:

(7) "Basic life support" means treatment of medical emergencies by a qualified person through the use of techniques ~~such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques~~ described in the Emergency Medical Technician Basic Training Course Curriculum or the National EMS Education Standards of the United States

Department of Transportation as approved by the department. The term ~~"basic life support"~~ also includes other techniques that ~~which~~ have been approved and are performed under conditions specified by rules of the department.

Section 3. Section 401.24, Florida Statutes, is amended to read:

401.24 Emergency medical services state plan.—The department is responsible, at a minimum, for the improvement and regulation of basic and advanced life support programs. The department shall develop, and ~~biennially~~ revise every 5 years, a comprehensive state plan for basic and advanced life support services, the emergency medical services grants program, trauma centers, the injury control program, and medical disaster preparedness. The state plan shall include, but need not be limited to:

(1) Emergency medical systems planning, including the prehospital and hospital phases of patient care, and injury control effort and unification of such services into a total delivery system to include air, water, and land services.

(2) Requirements for the operation, coordination, and ongoing development of emergency medical services, which includes: basic life support or advanced life support vehicles, equipment, and supplies; communications; personnel; training; public education; state trauma system; injury control; and other medical care components.

(3) The definition of areas of responsibility for regulating and planning the ongoing and developing delivery service requirements.

Section 4. Subsections (4) and (12) of section 401.27, Florida Statutes, are amended to read:

401.27 Personnel; standards and certification.—

(4) An applicant for certification or recertification as an emergency medical technician or paramedic must:

(a) Have completed an appropriate training course as follows:

1. For an emergency medical technician, an emergency medical technician training course equivalent to the most recent National EMS Education Standards ~~emergency medical technician basic training course~~ of the United States Department of Transportation as approved by the department;

2. For a paramedic, a paramedic training program equivalent to the most recent national standard curriculum or National EMS Education Standards ~~paramedic course~~ of the United States Department of Transportation as approved by the department;

(b) Certify under oath that he or she is not addicted to alcohol or any controlled substance;

(c) Certify under oath that he or she is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

(d) Within 2 years ~~1 year~~ after course completion have passed an examination developed or required by the department;

(e)1. For an emergency medical technician, hold ~~either~~ a current American Heart Association cardiopulmonary resuscitation course card or an American Red Cross cardiopulmonary resuscitation course card or its equivalent as defined by

department rule;

2. For a paramedic, hold a certificate of successful course completion in advanced cardiac life support from the American Heart Association or its equivalent as defined by department rule;

(f) Submit the certification fee and the nonrefundable examination fee prescribed in s. 401.34, which examination fee will be required for each examination administered to an applicant; and

(g) Submit a completed application to the department, which application documents compliance with paragraphs (a), (b), (c), (e), (f), (g), and, if applicable, (d). The application must be submitted so as to be received by the department at least 30 calendar days before the next regularly scheduled examination for which the applicant desires to be scheduled.

(12) An applicant for certification who is an out-of-state trained emergency medical technician or paramedic must provide proof of current emergency medical technician or paramedic certification or registration based upon successful completion of the United States Department of Transportation emergency medical technician or paramedic training curriculum or the National EMS Education Standards as approved by the department and hold a current certificate of successful course completion in cardiopulmonary resuscitation (CPR) or advanced cardiac life support for emergency medical technicians or paramedics, respectively, to be eligible for the certification examination. The applicant must successfully complete the certification examination within 1 year after the date of the receipt of his

or her application by the department. After 1 year, the applicant must submit a new application, meet all eligibility requirements, and submit all fees to reestablish eligibility to take the certification examination.

Section 5. Paragraph (a) of subsection (1) and subsection (5) of section 401.2701, Florida Statutes, are amended to read:

401.2701 Emergency medical services training programs.—

(1) Any private or public institution in Florida desiring to conduct an approved program for the education of emergency medical technicians and paramedics shall:

(a) Submit a completed application on a form provided by the department, which must include:

1. Evidence that the institution is in compliance with all applicable requirements of the Department of Education.

2. Evidence of an affiliation agreement with a hospital that has an emergency department staffed by at least one physician and one registered nurse.

3. Evidence of an affiliation agreement with a current ~~Florida-licensed~~ emergency medical services provider <u>that is licensed in this state</u>. Such agreement shall include, at a minimum, a commitment by the provider to conduct the field experience portion of the education program.

4. Documentation verifying faculty, including:

a. A medical director who is a licensed physician meeting the applicable requirements for emergency medical services medical directors as outlined in this chapter and rules of the department. The medical director shall have the duty and responsibility of certifying that graduates have successfully

completed all phases of the education program and are proficient in basic or advanced life support techniques, as applicable.

b. A program director responsible for the operation, organization, periodic review, administration, development, and approval of the program.

5. Documentation verifying that the curriculum:

a. Meets the ~~course guides and instructor's lesson plans in the~~ most recent Emergency Medical Technician-Basic National Standard Curricula or the National EMS Education Standards for emergency medical technician programs and paramedic ~~Emergency Medical Technician-Paramedic National Standard Curricula for paramedic~~ programs as approved by the department.

b. Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the department by rule.

~~c. Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of chapter 381.~~

6. Evidence of sufficient medical and educational equipment to meet emergency medical services training program needs.

(5) Each approved program must notify the department within 30 days after ~~of~~ any change in the professional or employment status of faculty. Each approved program must require its students to pass a comprehensive final written and practical examination evaluating the skills described in the current United States Department of Transportation EMT-Basic or EMT-Paramedic, National Standard Curriculum or the National EMS

Education Standards as approved by the department. Each approved program must issue a certificate of completion to program graduates within 14 days after ~~of~~ completion.

Section 6. This act shall take effect July 1, 2011.

CS/HB 959
Young

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 959 Administrative Monitoring of Mental Health and Substance Abuse Service Providers
SPONSOR(S): Health & Human Services Access Subcommittee; Young and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1366

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Access Subcommittee	15 Y, 0 N, As CS	Batchelor	Schoolfield
2) Health Care Appropriations Subcommittee		Pridgeon	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

CS/HB 959 amends s. 402.7306, F.S., which relates to administrative monitoring of service providers. The bill adds administrative, programmatic and licensure monitoring of mental health and substance abuse providers to the requirements of this section. In addition, the Behavioral Health Managing Entities under contract to the Department of Children and Families (DCF) and their contracted monitoring agents are added to the list of agencies affected by this section.

- The bill limits agencies who perform administrative, licensure, and programmatic monitoring of mental health and substance abuse providers to once every three years if the provider is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation.
- The bill limits the monitoring exceptions to services for which the provider is accredited to provide.
- The bill adds mental health and substance abuse service providers to the list of providers authorized to use an internet data warehouse for archiving administrative and fiscal records. An agency that conducts administrative monitoring of these service providers is required to use this data warehouse for document requests.

The bill, as drafted, would have a fiscal impact to the Agency for Health Care Administration (AHCA) based on the requirement to use a data warehouse that would allow external provider posting.

The bill provides an effective date upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Contract Monitoring

State agency procurement contracts typically include oversight mechanisms for contract management and program monitoring. Contract monitors ensure that contractually required services are delivered in accordance with the terms of the contract, approve corrective action plans for non-compliant providers, and withhold payment when services are not delivered or do not meet quality standards.

In November 2008, Children's Home Society of Florida (CHS) surveyed 162 contract programs, in an effort to "assess the quantity of external contract monitoring of CHS programs and identify any potential areas of duplication across monitoring by state and designated lead agencies.[1]"

According to the responses, between October 1, 2007 and September 30, 2008, 104 programs were monitored 154 times by state agencies, and 1,369 documents were requested in advance of site monitoring visits. Of the document requests, 488 (36 percent) were requested by other state agencies or other departments within a state agency during the past year. According to the survey, examples of duplicative document requests include:

- Finance and Accounting Procedures;
- Human Resources Policies and Procedures;
- List of Board of Directors and Board Meeting Minutes;
- Financial Audit and Management Letter;
- IRS forms;
- By-laws; and
- Articles of Incorporation.

During site visits, reviewers evaluated the same policies and procedures reviewed by other state agencies and professional program staff spent an average of 60 hours on each site visit.

House Bill 5305 (2010)

In 2010 the Legislature passed House Bill 5305[2] establishing s. 402.7306, F.S. to limit administrative monitoring to once every three years, if the contracted provider of child welfare services is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

HB 5305 also authorized private-sector development and implementation of an Internet-based secure and consolidated data warehouse for maintaining corporate, fiscal and administrative records related to child welfare provider contracts, and required state agencies that contract with child welfare providers to access records from this database.

Coordination of Contracted Services

The 2010 Legislature also passed Senate Bill 2386[3] creating s. 287.0575, F.S., requiring the coordination of contracted services related to providers under contract with DCF, the Agency for Persons with Disabilities (APD), the Department of Health (DOH), the Department of Elder Affairs (DOEA), and the Department of Veterans Affairs (DVA).

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[1] CHS, *Case Study-Contract Monitoring Survey* (December 3, 2008).
[2] Chapter 2010-158 L.O.F.
[3] Chapter 2010-151 L.O.F.

This section of law provides that contract service providers must provide contract managers with comprehensive lists of their health and human services contracts if they have more than one contract with more than one agency, establish a single lead administrative coordinator for each contract service provider among agencies having multiple contracts, and requires that each agency contracting for health and human services annually evaluate the performance of the designated lead coordinator.[4]

Behavioral Health Managing Entities

Behavioral Health Managing Entities are established in s 394.9082, F.S., to provide more efficient oversight and coordination of mental health and substance abuse service programs under DCF. The managing entity is under contract with DCF to manage the day-to-day operational delivery of behavioral health services through an organized system of care.[5] The goal is to effectively coordinate, integrate and manage the delivery of behavioral health services.[6]

Current Licensure Authority

Mental health providers are licensed by AHCA under the authority of chapter 394 Part IV, F.S. Substance Abuse providers are licensed by DCF under the authority of s. 397.401, F.S. In addition, s. 394.741, F.S. provides that accreditation must be accepted as a substitute for facility onsite licensure review and administrative and programmatic requirements for mental health and substance abuse treatment services.[7]

Child welfare providers are licensed as child placing agencies and residential child caring agencies by DCF under the authority of s. 409.175, F.S.

Effect of Proposed Changes

The Committee Substitute for HB 959 amends s. 402.7306, F.S., which relates to administrative monitoring of service providers. The bill adds administrative, programmatic and licensure monitoring of mental health and substance abuse providers to the requirements of this section. In addition, the Behavioral Health Managing Entities under contract to the DCF and their contracted monitoring agents are added to the list of agencies affected by this section.

The bill limits agencies who perform administrative, licensure, and programmatic monitoring of mental health and substance abuse providers to once every three years if the provider is accredited by JCAHO, CARF, or COA. The bill limits the monitoring exception to the services the provider is accredited for.

Finally, the bill adds mental health and substance abuse service providers to the list of providers authorized to use an internet data warehouse for archiving administrative and fiscal records. An agency that conducts administrative monitoring of these service providers is required to use this data warehouse for document requests.

B. SECTION DIRECTORY:

Section 1: Amends s. 402.7306, F.S., relating to administrative monitoring.

Section 2: Provides an effective date upon becoming law.

[4] s. 287.0575, F.S.
[5] s. 394.9082(2)(d), F.S.
[6] s. 394.9082(5), F.S.
[7] s. 394.741, F.S.,

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The bill, as drafted, would require AHCA to create an online application that would allow each provider to have a user account by which they can be uniquely identified to enable submission of information and documentation. An example of information required for licensure but not accreditation, may be information required for license renewal such as proof of insurance, background screening, disclosure of ownership and controlling interests, and adverse incident reporting. The exact cost to implement such a system is indeterminate, but expected to be significant.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Mental Health and Substance Abuse providers will experience fewer monitoring visits and are allowed to place corporate, fiscal, and administrative records on a secure internet-based data warehouse for agency review. This will allow the providers more time to deliver direct services.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

None

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill, as drafted, appears to conflict with s. 408.811, F.S., which provides AHCA right of entry to facilities at any time. Additionally, not all accrediting organizations would be recognized by the federal government. In the case of AHCA, this would be the federal Centers for Medicare and Medicaid Services (CMS) to be equivalent to federal standards. If AHCA were acting as an agent of CMS for certification, they would still need to follow the federal requirements. For programs that AHCA

recognizes accreditation in lieu of inspection, AHCA would need to maintain authority to conduct validation inspections generally conducted for a sample of facilities to validate the accreditations oversight.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2011, the Health & Human Services Access Subcommittee adopted one amendment to House Bill 959.

The amendment provides for limitations on administrative, programmatic and licensure monitoring of mental health and substance abuse providers and separates them from administrative monitoring of child welfare providers.

The bill limits the monitoring exception to the services the provider is accredited for.
The bill was reported favorably as a Committee Substitute. This analysis reflects the Committee Substitute.

A bill to be entitled

An act relating to administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers; amending s. 402.7306, F.S.; including mental health and substance abuse providers for purposes of administrative, licensure, and programmatic monitoring; requiring the Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, community-based care lead agencies, managing entities, and contracted monitoring agents to adopt policies for the monitoring of child welfare, mental health, and substance abuse service providers; limiting the frequency of administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers under certain conditions; providing a definition; exempting Medicaid certification and precertification reviews from certain monitoring requirements; providing for certain documentation to be posted by the provider on a data warehouse; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 402.7306, Florida Statutes, is amended to read:

402.7306 Administrative monitoring <u>of</u> ~~for~~ child welfare <u>service</u> providers<u>; administrative, licensure, and programmatic</u>

monitoring of mental health and substance abuse service providers.—The Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, ~~and~~ community-based care lead agencies, managing entities, as defined in s. 394.9082, and contracted monitoring agents of the agencies shall identify and implement changes that improve the efficiency of administrative monitoring of child welfare services and administrative, licensure, and programmatic monitoring of mental health and substance abuse services. To assist with that goal, each such agency shall adopt the following policies:

(1) Limit administrative monitoring of child welfare service providers to once every 3 years if the service ~~child welfare~~ provider is accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Children and Family Services. If the accrediting body does not require documentation that the state agency requires, that documentation shall be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints or suspected problems and

monitoring the service provider's compliance with any resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Medicaid certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

(2) Limit administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers to once every 3 years if the service provider is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Children and Family Services. For the purpose of this section, "mental health and substance abuse service provider" means a provider who provides services to the state's priority populations as described in s. 394.674. If the services being monitored are not the services for which the provider is accredited, the limitations of this subsection do not apply. If the accrediting body does not require the documentation that the state agency requires, that documentation shall be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this

section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints, identifying problems that would affect the safety or viability of the service provider, and monitoring the service provider's compliance with any resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Medicaid certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

(3) ~~(2)~~ Allow private sector development and implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of child welfare, mental health, or substance abuse service providers. A service provider shall ensure that the data is up to date and accessible to the applicable agency under this section and the appropriate agency subcontractor. A service provider shall submit any revised, updated information to the data warehouse within 10 business days after receiving the request. An agency that conducts administrative monitoring of child welfare, mental health, or

substance abuse service providers under this section must use the data warehouse for document requests. If the information provided to the agency by the service provider's data warehouse is not current or is unavailable from the data warehouse and archive, the agency may contact the service provider directly. A service provider that fails to comply with an agency's requested documents may be subject to a site visit to ensure compliance. Access to the data warehouse must be provided without charge to an applicable agency under this section. At a minimum, the records must include the service provider's:

(a) Articles of incorporation.

(b) Bylaws.

(c) Governing board and committee minutes.

(d) Financial audits.

(e) Expenditure reports.

(f) Compliance audits.

(g) Organizational charts.

(h) Governing board membership information.

(i) Human resource policies and procedures.

(j) Staff credentials.

(k) Monitoring procedures, including tools and schedules.

(l) Procurement and contracting policies and procedures.

(m) Monitoring reports.

Section 2. This act shall take effect upon becoming a law.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative(s) Young offered the following:

Amendment (with title amendment)

Remove lines 68-101 and insert:

(2) Limit administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers to once every 3 years if the service provider is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Children and Family Services. For the purpose of this section, "mental health and substance abuse service provider" means a provider regulated or licensed under chapters 394 or 397, who provides services to the state's priority populations as described in s. 394.674. If the services being

monitored are not the services for which the provider is accredited, the limitations of this subsection do not apply. If the accrediting body does not require the documentation that the state agency requires, that documentation shall be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review, except documents related to licensure applications and fees. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints, identifying problems that would affect client safety or viability of the service provider, and monitoring the service provider's compliance with any resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not

Amendment No. 1

duplicate the accrediting organization's review pursuant to accreditation standards.

Federal certification and precertification reviews are exempt from this subsection to ensure federal compliance.

T I T L E A M E N D M E N T

Remove line 17 and insert:

providing a definition; exempting federal certification

CS/HB 1319
Harrell

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1319 Temporary Certificates and Licenses for Certain Health Care Practitioners
SPONSOR(S): Health & Human Services Quality Subcommittee; Harrell and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1228

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	11 Y, 0 N, As CS	Holt	Calamas
2) Health Care Appropriations Subcommittee		Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Currently, the Department of Health (DOH) does not issue temporary licenses to health care practitioners who are spouses of active duty members of the Armed Forces. The bill provides the DOH the authority to issue a temporary license to a healthcare practitioner whose spouse is stationed in Florida on active duty with the Armed Forces if the applicant meets the eligibility requirements for a full license and is qualified to take the licensure examination. The temporary license is valid for six months from the date of issuance and is not renewable. The healthcare practitioner is required to:

- Submit a completed application;
- Submit a fee;
- Provide proof of marriage to an active duty member of the Armed Forces of the United States assigned to a duty station in Florida;
- Provide proof of a valid license in another state, the District of Columbia, a possession or territory of the United States, and is not the subject of any disciplinary proceeding;
- Provide proof that they have actively practiced the profession for at least 3 years; and
- Complete state and national criminal history checks as required by the applicable practice act.

The bill requires the applicable board or DOH if there is no board, to deny applications under certain circumstances. The bill requires the applicant for a temporary license to pay the cost for the fingerprint processing, and an application fee.

The bill names the temporary certificate for practice in areas of critical need the "Rear Admiral Leroy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

There is expected to be a positive fiscal impact to the Medical Quality Assurance Trust Fund through the increased application fee collections. The fiscal impact to DOH is expected to be insignificant and any impacts can be absorbed within existing departmental resources.

The bill provides for an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background
Health Care Practitioner Licensure

The Department of Health (DOH), Division of Medical Quality Assurance (MQA) regulates more than 40 health care professions and 37 types of facilities/establishments.[1] MQA evaluates the credentials of all applicants for licensure, issues licenses, analyzes and investigates complaints, inspects facilities, assists in prosecuting practice act violations, combats unlicensed activity, and provides credentials and discipline history about licensees to the public. In Fiscal Year 2009-2010, MQA issued a total of 1,002,920 licensees.[2]

Currently, the DOH does not issue temporary licenses to health care practitioners who are spouses of active duty members of the Armed Forces. All health care practitioners are required to comply with the licensing provisions specified for the health care profession and corresponding practice act[3] that they are seeking to be licensed under. The board (or DOH if there is no board), determines whether DOH should issue a license to practice in Florida.

In Fiscal Year 2009-2010, the average number of days to issue a license was 56.5 days. This is calculated from the date an application is received by the Department to the date the license is issued. However, the 56.5 days includes steps in the process that are outside of the DOH's control:[4]

- Most professions have national licensure exams. For those professions where candidates who are permitted to apply for licensure prior to passing the exam, the length of time it takes to pass the exam impacts the number of days to issue a license.
- Length of time it takes for an applicant to successfully pass a practical licensure exam. Florida currently administers some state practical licensure exams. Those exams are administered a limited number of times per year. The dental exam is administered 3 times per year; the dental hygiene exam is administered 2 times per year; the opticianry exam is administered twice per year; optometry is administered one time per year.
- Some professions are required to have taken certain educational courses, therefore those applicants are required to successfully pass college courses while the application is pending; (See s. 491.005, F.S.,).
- For professions which require a criminal background check, delays are often experienced while the applicant obtains and sends in information from law enforcement or the judicial system detailing the disposition of an arrest or conviction.
- Pre-licensure facility inspections.

Criminal Background Screening

In 1995, the Florida Legislature created standard procedures for the screening of prospective employees where the Legislature had determined it necessary to conduct criminal history background checks to protect vulnerable persons. Currently, there are two different levels of criminal background screenings: statewide (Level 1), national (Level II). Chapter 435, F.S., outlines the screening standards for Level 1 employment screening and Level 2 employment screening. The Florida Department of Law Enforcement (FDLE) provides criminal history checks to the employer.

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[1] Florida Department of Health, Division of Medical Quality Assurance, Reports and Publications, 2009-2010 Annual Report, *available* at: http://www.doh.state.fl.us/mqa/reports.htm (last viewed March 17, 2011).
[2] *Id.*
[3] "Practice Acts" are in statute for each profession and establish the scope and standards of practice of the profession, and provide grounds for disciplinary action.
[4] Per email correspondence with DOH, Medical Quality Assurance staff, March 17, 2011, on file with Health & Human Services Quality Subcommittee staff.

The provisions of chapter 435, F.S., apply whenever a Level 1 or Level 2 screening for employment is required by law. Screenings can be done following Level 1 or Level 2 standards, depending on what direction is provided in a specific statute.

Level 1 screenings are name-based demographic screenings that must include, but are not limited to, employment history checks and statewide criminal correspondence checks through FDLE. Level 1 screenings may also include local criminal records checks through local law enforcement agencies. Anyone undergoing a Level 1 screening must not have been found guilty of any of many offenses delineated by law.[5]

A Level 2 screening consists of a fingerprint-based search of FDLE and the Federal Bureau of Investigations (FBI) databases for state and national criminal arrest records. Any person undergoing a Level 2 screening must not have been found guilty of any of the offenses for Level 1 or the many offenses delineated by law.[6]

Currently, DOH conducts different levels of background screening for health professions as required by each practice act:[7]

Regulated Provider Type/Licensee Initial Licensure	Current Level of Screening	Cost of screening and who pays the cost (See note)	Rescreening Requirements
Advanced Registered Nurse Practitioner	Statewide/National	$43.25/Licensee	Renewal - Statewide
Certified Nursing Assistant by Examination in FL > 5 years	Level II	$43.25/Licensee	None
Certified Nursing Assistant by Examination in FL < 5 years	Level II	$43.25/Licensee	None
Certified Nursing Assistant by Reciprocity	Level II	$43.25/Licensee	None
Licensed Practical Nurse by Examination	Statewide	$24/Licensee	None
Licensed Practical Nurse by Endorsement	Statewide/National	$43.25/Licensee	None
Registered Nurse by Examination	Statewide	$24/Licensee	None
Registered Nurse by Endorsement	Statewide/National	$43.25/Licensee	None
Chiropractic Physician	Statewide/National	$43.25/Licensee	Renewal - Statewide
Medical Doctor	Statewide/National	$43.25/Licensee	Renewal - Statewide
Osteopathic Physician	Statewide/National	$43.25/Licensee	Renewal - Statewide
Orthotists, Prosthetists, Pedorthists, Orthotic Fitters, Orthotic Fitter Assistants, O&P Resident	Statewide/National	$43.25/Licensee	Renewal - Statewide
Drug Wholesalers/Certified Designated Representative	Statewide/National	$43.25/Licensee	None
Pharmacy Owner	Statewide/National	$43.25/Licensee	None
Prescription Department Manager	Statewide/National	$43.25/Licensee	None
Podiatric Physician	Statewide/National	$43.25/Licensee	Renewal - Statewide

Source: Department of Health, Division of Medical Quality Assurance[8]
Note : DOH charges $4.75 administrative processing fee

Many health professions do not require a criminal background screening at the time of initial licensure or licensure renewal. Currently, the following health professions are not subject to a criminal background screening:[9]

- Acupuncture

[5] *See* ss. 393.135, 394.4593, 415.111, 782.04, 782.07, 782.071, 782.09, 784.011, 784.021, 784.03, 784.045, 787.01, 787.02, 794.011, 794.041, 798.02, 806.01, 817.563, 825.102, 825.1025, 825.103, 826.04, 827.03, 827.04, 827.05, 827.071, 916.1075 and chapters 796, 800, 812, 847, and 893, F.S.
[6] *See* ss. 787.04(2), 787.04(3), 790.115(1), 790.115(2)(b), 843.01, 843.025, 843.12, 843.13, 874.05(1), 944.35(3), 944.46, 944.47, 985.701, and 985.711, F.S.
[7] Florida Department of Health, Division of Medical Quality Assurance, Background Screening, Background Screening Matrix, *available* at: http://www.doh.state.fl.us/mqa/background.html (last viewed March 17, 2011).
[8] *Id.*
[9] Per email correspondence with DOH, Medical Quality Assurance staff, March 17, 2011, on file with Health & Human Services Quality Subcommittee staff.

- Anesthesiologist Assistant
- Athletic Training
- Clinical Laboratory Personnel
- Clinical Nurse Specialist
- Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Dentistry/Dental Laboratory
- Dietetics/Nutrition
- Electrolysis/Electrolysis Facility
- Emergency Medical Technician
- Hearing Aid Specialist
- Massage Therapy/Massage Establishment
- Medical Physicist
- Midwifery
- Naturopath
- Nursing Home Administrator
- Office Surgery Registration

According to DOH, the results of a state or national background screening are reviewed by the applicant's respective health profession board and the results are used to decide whether to grant a license. However, this screening process does not meet the definition of a Level II screening as provided in chapter 435, F.S.[10]

Temporary Certificate for Practice in Areas of Critical Need

A physician is eligible to receive a temporary certificate to practice in an area of critical (certificate) need if:[11]

- They hold a valid licensed to practice in any jurisdiction in the United States; or
- They have served as a physician in the United States Armed Forces for at least 10 years and received an honorable discharge from the military; and
- Pays an application fee of $300.

The State Surgeon General is tasked with determining the areas of critical need.[12] Such areas may include a health professional shortage area designated by the United States Department of Health and Human Services.[13] The certificate is valid for as long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The Board of Medicine is required to review each certificate holder annually to ensure compliance with the Medical Practice Act.[14]

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[10] Florida Department of Health, Division of Medical Quality Assurance, Background Screening, Criminal Background Screening & Exemption, *available* at: http://www.doh.state.fl.us/mqa/background.html (last viewed March 17, 2011).
[11] s. 458.315(1) and 459.0076, F.S.
[12] s. 458.315 (3) and 459.0076(3), F.S.
[13] Health Professional Shortage Areas (HPSAs) are defined in §332 of the Public Health Service Act, 42 U.S.C. 254e to include: (1) urban and rural geographic areas, (2) population groups, and (3) facilities with shortages of health professionals. The federal designation as a HPSA documents a shortage of health care providers (primary care, dental or mental health) as well as the existence of barriers to accessing care including lack of public transportation, travel time and distance to the next source of undesignated care and high poverty. To be eligible for designation, a geographic area or a population group (a low income or migrant population) must have a population-to-physician ratio greater than 3,000 to one. *See* Florida Department of Health, Division of Health Access and Tobacco, Office of Health Professional Recruitment, *available* at: http://www.doh.state.fl.us/workforce/recruit1/shortdesig.html (last viewed March 24, 2011).
[14] s. 458.315 (3) and 459.0076(3), F.S.

Rear Admiral LeRoy Collins, Jr.

Rear Admiral LeRoy Collins, Jr., died July 29, 2010, in Tampa, Florida, at the age of 75. He was a native of Tallahassee and the son of former Florida Governor LeRoy Collins. He graduated from the U.S. Naval Academy in 1956, embarking upon a 34-year military career and retiring as a two-star Rear Admiral in 1990.[15] In 2007, Governor Charlie Crist appointed Admiral Collins the executive director of the Florida Department of Veterans' Affairs. Admiral Collins founded the Florida Veterans Foundation, Inc.[16]

Admiral Collins was also instrumental in the growth of electronic payment systems in the United States, starting with the introduction of credit cards in Florida and the Southeast. As the founder and president of the Armed Forces Financial Network, Admiral Collins pioneered the deployment of ATMs and point-of-sale devices in U.S. military installations worldwide, including major U.S. aircraft carriers. He also held several other positions, including founding president of Financial Transaction Systems, Inc. and a senior executive of Telecredit Service Center, Inc.[17]

The Effects of the Bill

The bill provides the Department of Health (DOH) the authority to issue a temporary license to a healthcare practitioner whose spouse is stationed in Florida on active duty with the Armed Forces. The temporary license is valid for six months from the date of issuance and is not renewable. The healthcare practitioner is required to:

- Submit a completed application;
- Submit a fee;
- Provide proof of marriage to an active duty member of the Armed Forces of the United States assigned to a duty station in Florida;
- Provide proof of a valid license in another state, the District of Columbia, a possession or territory of the United States and is not the subject of any disciplinary proceeding;
- Provide proof that they have actively practiced the profession for at least 3 years;
- Provide proof that they would be entitled to full licensure and eligible to take the licensure examination;
- Complete state and national criminal history checks as required by the applicable practice act.

The bill provides that a temporary license is denied if:

- The applicant is the subject of any disciplinary action in any jurisdiction,
- The applicant is ineligible for full licensure;
- The applicant is ineligible to take the applicable licensure examination;
- The applicant is convicted of or pled nolo contendere to any felony or misdemeanor related to the practice of a health care profession;
- The applicant had a health care license revoked or suspended in another jurisdiction
- The applicant has been reported to the National Practitioner Databank; or
- The applicant failed a Florida-administered dental examination.

The bill requires the board or the DOH if there is no board, to review the results of any criminal background check and approve or deny the application consistent with the requirements of the applicable practice act. The bill gives DOH or the board authority to request the personal appearance of an applicant and deny the application for those who refuse, and deny an applicant who is under investigation or prosecution that would constitute a violation of the applicable practice act. The bill requires the applicant for a temporary license to pay the cost for the fingerprint processing, and an application fee.

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[15] Collins Center for Public Policy, LeRoy Collins, Jr., Obituary, *available* at: http://www.collinscenter.org/?page=LCJr_ObituaryPage (last viewed March 25, 2011).
[16] Collins Center for Public Policy, LeRoy Collins, Jr., Trustee Biography, *available* at: http://www.collinscenter.org/?page=TrusteeBioCollinsJr (last viewed March 25, 2011).
[17] *Supra*, note 15.

The bill names the temporary certificate for practice in areas of critical need the "Rear Admiral Leroy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

B. SECTION DIRECTORY:

Section 1. Amends s. 456.024, F.S., relating to members and spouses of Armed Forces in good standing with administrative boards or the department.
Section 2. Amends s. 458.315, F.S., relating to the temporary certificate for practice in areas of critical need.
Section 3. Amends s. 459.0076, F.S., relating to the temporary certificate for practice in areas of critical need.
Section 4. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill authorizes the DOH to set the application fee for the temporary license. According to the DOH, there are 14 military bases in Florida, yet the number of out of state military personnel stationed in Florida, the number out of state military personnel with spouses, and the number of spouses that are health care practitioners licensed in other states is unknown. Therefore, it is unknown how many temporary license applications will be submitted; however the revenue generated will not exceed the cost of issuing the license.

2. Expenditures:

The fiscal impact is indeterminate; however it is expected to be insignificant and can be absorbed within existing departmental resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill authorizes the DOH to set the application fee for the temporary license and the applicant is required to pay the cost for fingerprint processing.

D. FISCAL COMMENTS:

Section 216.0236, F.S., provides that the all costs of providing a regulatory service or regulating a profession or business be borne solely by those who are regulated and the program be self-sufficient.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The department does not need additional rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 22, 2011, the Health and Human Services Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Removes provision allowing a licensee from a foreign jurisdiction from being eligible for a temporary license.
- Requires applicants to have actively practiced for at least 3 years
- Adds provisions denying a temporary license if:
  - The applicant is the subject of any disciplinary action in any jurisdiction,
  - The applicant is ineligible for full licensure;
  - The applicant is ineligible to take the applicable licensure examination;
  - The applicant is convicted of or pled nolo contendere to any felony or misdemeanor related to the practice of a health care profession;
  - The applicant had a health care license revoked or suspended in another jurisdiction
  - The applicant has been reported to the National Practitioner Databank; or
  - The applicant failed a Florida-administered dental examination.
- Requires applicants to meet the criminal background screening requirements of their applicable practice act, and requires DOH or the board to review of results of and deny or approve the application consistent with requirements of the applicable practice act.
- Gives DOH or the board authority to request the personal appearance of an applicant and deny the application for those who refuse, and deny an applicant who is under investigation or prosecution that would constitute a violation of the applicable practice act.
- Names the temporary certificate for practice in areas of critical need the "Rear Admiral Leroy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

This analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to temporary certificates and licenses for certain health care practitioners; amending s. 456.024, F.S.; providing for issuance of a temporary license to specified health care practitioners who are spouses of active duty members of the Armed Forces under certain circumstances; providing for criminal history checks; providing fees; providing for expiration of a temporary license; providing that temporary licensees are subject to specified general licensing requirements; amending ss. 458.315 and 459.0076, F.S.; naming temporary certificates issued to physicians who practice in areas of critical need as the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need"; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) is added to section 456.024, Florida Statutes, to read:

456.024 Members of Armed Forces in good standing with administrative boards or the department; spouses.—

(3)(a) The board, or the department when there is no board, may issue a temporary professional license to the spouse of an active duty member of the Armed Forces of the United States who submits to the department:

1. A completed application upon a form prepared and furnished by the department in accordance with the board's

rules;

2. The required application fee;

3. Proof that the applicant is married to a member of the Armed Forces of the United States who is on active duty;

4. Proof that the applicant holds a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the United States, and is not the subject of any disciplinary proceeding in any jurisdiction in which the applicant holds a license to practice a profession regulated by this chapter;

5. Proof that the applicant has actively practiced the profession for a period of no less than 3 years;

6. Proof that the applicant's spouse is assigned to a duty station in this state pursuant to the member's official active duty military orders; and

7. Proof that the applicant would otherwise be entitled to full licensure under the appropriate practice act and is eligible to take the respective licensure examination as required in Florida. The applicant shall comply with any criminal background check requirements contained in the applicable practice act, except as otherwise provided in this section. The board, or the department if there is no board, shall review the results of any criminal background check and shall deny or approve the application consistent with the applicable practice act. The applicant shall pay the cost of fingerprint processing. If the fingerprints are submitted through an authorized agency or vendor, the agency or vendor shall collect the required processing fees and remit the fees to

the Department of Law Enforcement.

(b) An applicant is ineligible for a temporary license pursuant to this section if the applicant:

1. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

2. Has had a health care provider license revoked or suspended from another state, the District of Columbia, or a United States territory;

3. Has been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank; or

4. Has previously failed a Florida-administered examination that is required to receive a license pursuant to s. 466.006.

(c) The board, or department when there is no board, may revoke a temporary license upon a finding that the individual violated the profession's governing practice act.

(d) The department shall set an application fee, which may not exceed the cost of issuing the license.

(e) A temporary license expires 6 months after the date of issuance and is not renewable.

(f) A person issued a temporary license under this subsection is subject to the requirements of s. 456.013(3)(a) and (c).

Section 2. Present subsections (1) through (4) of section 458.315, Florida Statutes, are renumbered as subsections (2) through (5), respectively, and a new subsection (1) is added to

that section, to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A certificate issued pursuant to this section may be cited as the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

Section 3. Present subsections (1) through (4) of section 459.0076, Florida Statutes, are renumbered as subsections (2) through (5), respectively, and a new subsection (1) is added to that section, to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A certificate issued pursuant to this section may be cited as the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

Section 4. This act shall take effect July 1, 2011.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Harrell offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (3) is added to section 456.024, Florida Statutes, to read:

456.024 Members of Armed Forces in good standing with administrative boards or the department; spouses.—

(3)(a) The board, or the department if there is no board, may issue a temporary professional license to the spouse of an active duty member of the Armed Forces of the United States who submits to the department:

1. A completed application upon a form prepared and furnished by the department in accordance with the board's rules;

2. The required application fee;

3. Proof that the applicant is married to a member of the Armed Forces of the United States who is on active duty;

4. Proof that the applicant holds a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the United States, and is not the subject of any disciplinary proceeding in any jurisdiction in which the applicant holds a license to practice a profession regulated by this chapter;

5. Proof that the applicant's spouse is assigned to a duty station in this state pursuant to the member's official active duty military orders; and

6. Proof that the applicant would otherwise be entitled to full licensure under the appropriate practice act, and is eligible to take the respective licensure examination as required in Florida.

(b) The applicant must also submit to the Department of Law Enforcement a complete set of fingerprints. The Department of Law Enforcement shall conduct a statewide criminal history check and forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check.

(c) Each board, or the department if there is no board, shall review the results of the state and federal criminal history checks according to the level 2 screening standards in s. 435.04 when granting an exemption and when granting or denying the temporary license.

(d) The applicant shall pay the cost of fingerprint processing. If the fingerprints are submitted through an authorized agency or vendor, the agency or vendor shall collect

the required processing fees and remit the fees to the Department of Law Enforcement.

(e) The department shall set an application fee, which may not exceed the cost of issuing the license.

(f) A temporary license expires 12 months after the date of issuance and is not renewable.

(g) An applicant for a temporary license under this subsection is subject to the requirements under s. 456.013(3)(a) and (c).

(h) An applicant shall be deemed ineligible for a temporary license pursuant to this section if the applicant:

1. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

2. Has had a health care provider license revoked or suspended from another of the United States, the District of Colombia, or a United States Territory;

3. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank; or

4. Has previously failed the Florida examination required to receive a license to practice the profession for which the applicant is seeking a license.

(i) The board, or department if there is no board, may revoke a temporary license upon finding that the individual violated the profession's governing practice act.

(j) An applicant who is issued a temporary professional license to practice as a dentist pursuant to this section must

practice under the indirect supervision, as defined in s. 466.003, of a dentist licensed pursuant to chapter 466.

Section 2. Present subsections (1) through (4) of section 458.315, Florida Statutes, are renumbered as subsections (2) through (5), respectively, and a new subsection (1) is added to that section, to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A certificate issued pursuant to this section may be cited as the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

Section 3. Present subsections (1) through (4) of section 459.0076, Florida Statutes, are renumbered as subsections (2) through (5), respectively, and a new subsection (1) is added to that section, to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A certificate issued pursuant to this section may be cited as the "Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Practice in Areas of Critical Need."

Section 4. This act shall take effect July 1, 2011.

T I T L E A M E N D M E N T

Remove the entire title and insert:

A bill to be entitled

Amendment No. 1

An act relating to temporary certificates and licenses for certain health care practitioners; amending s. 456.024, F.S.; providing for issuance of a temporary license to specified health care practitioners who are spouses of active duty members of the Armed Forces under certain circumstances; providing for criminal history checks; providing fees; providing for expiration of a temporary license; requiring a person who is issued a temporary license to be subject to certain general licensing requirements; providing that certain persons are ineligible for such license; providing for revocation of such license; requiring certain temporary licensees to practice under the indirect supervision of other licensees; amending ss. 458.315 and 459.0076, F.S.; naming the temporary certificates issued to physicians who practice in areas of critical need after Rear Admiral LeRoy Collins, Jr.; providing an effective date.

Amendment to Amendment 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Harrell offered the following:

Amendment to Amendment (37114) by Representative Harrell (with title amendment)

Remove line 95 and insert:

Section 4. Effective January 1, 2012, section 466.006, Florida Statutes, is amended to read:

466.006 Examination of dentists.—

(1)(a) It is the intent of the Legislature to reduce the costs associated with an independent state-developed practical or clinical examination to measure an applicant's ability to practice the profession of dentistry and to use the American Dental Licensure Examination developed by the American Board of Dental Examiners, Inc., in lieu of an independent state-developed practical or clinical examination. The Legislature finds that the American Dental Licensure Examination, in both its structure and function, has been approved and validated by

both the board and the Legislature as consistently meeting generally accepted testing standards and has been found, as it is currently organized and operating, to adequately and reliably measure an applicant's ability to practice the profession of dentistry.

(b) Any person desiring to be licensed as a dentist shall apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application shall include two recent photographs. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee set by the board, which shall not exceed $425 plus the actual per applicant cost to the department for purchase of some or all ~~portions~~ of the examination from the American Board of Dental Examiners or its successor entity, if any, provided the board finds the successor entity's clinical examination complies with the provisions of this section. The examination fee ~~Northeast Regional Board of Dental Examiners or a similar national organization, which~~ may be refundable if the applicant is found ineligible to take the examinations. The American Dental Licensure Examination is not a national examination requiring certification by the department pursuant to s. 456.017(1)(a).

(2) An applicant shall be entitled to take the examinations required in this section to practice dentistry in this state if the applicant:

(a) Is 18 years of age or older.

(b)1. Is a graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation ~~Commission on Accreditation of the American Dental Association~~ or its successor entity ~~agency~~, if any, or any other dental ~~nationally recognized~~ accrediting entity recognized by the United States Department of Education ~~agency~~; or

2. Is a dental student in the final year of a program at such an accredited dental school located in this state who has completed all the coursework necessary to prepare the student to perform the clinical and diagnostic procedures required to pass the examinations. With respect to a dental student in the final year of a program at a dental school, a passing score on the examinations is valid for 365 ~~180~~ days after the date the examinations were completed. A dental school student who takes the licensure examinations during the student's final year of an approved dental school must have graduated before being certified for licensure pursuant to s. 466.011.

(c)1. Has successfully completed the National Board of Dental Examiners dental examination at any time prior to ~~within 10 years of~~ the date of application; or

2. Has an active health access dental license in this state; and

a. The applicant has at least 5,000 hours within 4 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003(14); the applicant is a retired veteran dentist of any branch of the United States Armed Services who has practiced dentistry while on active duty and has at least 3,000 hours

within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003(14); or the applicant has provided a portion of his or her salaried time teaching health profession students in any public education setting, including, but not limited to, a community college, college, or university, and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003(14);

b. The applicant has not been disciplined by the board, except for citation offenses or minor violations;

c. The applicant has not:

(I) Filed a report pursuant to s. 456.049 or s. 627.912;

(II) Informed a patient or an individual identified pursuant to s. 765.401(1) about an adverse incident as required pursuant to s. 456.0575; or

(III) Reported information related to a bankruptcy proceeding pursuant to s. 456.051(2); and

d. The applicant has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession.

~~(3) If an applicant is a graduate of a dental college or school not accredited in accordance with paragraph (2)(b) or of a dental college or school not approved by the board, the applicant shall not be entitled to take the examinations required in this section to practice dentistry until she or he satisfies one of the following:~~

~~(a) Completes a program of study, as defined by the board by rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or~~

~~(b) Completes a 2-year supplemental dental education program at an accredited dental school and receives a dental diploma, degree, or certificate as evidence of program completion.~~

(3)~~(4)~~ Effective January 1, 2012, and notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations ~~s. 456.017(1)(c)~~, to be licensed as a dentist in this state, an applicant must successfully complete the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry;

(b)1. A practical or clinical examination, which, effective January 1, 2012, and thereafter, shall be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, that is administered in this state and graded by dentists licensed in this state and employed by the department for just such purpose, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. A passing score on the American Dental Licensure Examination administered

in this state and graded by Florida dentists is valid for 365 days after the date the examination was successfully completed. The board shall develop and adopt rules that specify the general areas of competency to be covered by the examination, the relative weight to be assigned in rating each area tested, the score necessary to achieve a passing grade, the criteria by which examiners are to be selected, the grading criteria to be used by the examiner, and rules regarding the security and monitoring of the examination.

2. As an alternative to subparagraph 1., an applicant may submit scores from an American Dental Licensure Examination previously administered in a jurisdiction other than this state, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensure Examination administered out-of-state shall be the same as the passing score for the American Dental Licensure Examination administered in this state and graded by dentists who are licensed in this state. The examination results are valid for 365 days after the date on which the examination was successfully completed. The applicant must complete the examination after January 1, 2012. This subparagraph may not be given retroactive application.

3. If the date of an applicant's passing American Dental Licensure Examination scores from an examination previously administered in a jurisdiction other than this state is older than 365 days, then such scores shall nevertheless be recognized as valid for the purpose of licensure in this state, but only if

the applicant demonstrates to the satisfaction of the board that all of the following additional standards have been met:

a. The applicant completed the American Dental Licensure Examination after January 1, 2012. This sub-subparagraph may not be given retroactive application;

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education, provided, however, that if the applicant did not graduate from such a dental school, then the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. This program must provide didactic and clinical education to the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation;

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

d. The applicant has never been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards

Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies;

e.(I) In the 5 years immediately preceding the date of application for licensure in this state, the applicant must submit proof of being consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico; or, in the alternative, if the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant must submit proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full time practice" is defined as a minimum of 1,200 hours per year for each and every year in the consecutive 5-year period or, where applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by

the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) Submitted by the applicant under oath with penalties of perjury attached;

(D) Further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice; and

(E) Specifically found by the board to be both credible and admissible.

(IV) The board must make specific findings of fact and conclusions of law regarding the credibility and admissibility of proffered evidence and such findings and conclusions of law are final agency action under chapter 120. An affidavit of only the applicant is not acceptable proof regarding full-time practice unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath.

f. The applicant must submit documentation that he or she has completed, or will complete, prior to licensure in this state, continuing education equivalent to this state's requirements for the last full reporting biennium;

g. The applicant must prove that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction;

h. The applicant must successfully pass a written examination on the laws and rules of this state regulating the practice of dentistry and must successfully pass the computer-based diagnostic skills examination during the year preceding the date of the application; and

i. The applicant must submit documentation that he or she has successfully completed the National Board of Dental Examiners dental examination prior to the date of application.

(4)(a) The practical examination required under subsection (3) shall be the American Dental Licensure Examination developed by the American Board of Dental Examiners, Inc., or its successor entity, if any, provided the board finds that the successor entity's clinical examination complies with the provisions of this section, and shall include, at a minimum:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied clinical diagnosis and treatment planning in dentistry for dental candidates.

2.~~a.~~ Two restorations on a live patient or patients, and the board by rule shall determine the class of such

restorations. ~~and whether they shall be performed on mannequins, live patients, or both. At least one restoration shall be on a live patient;~~

3.~~b.~~ A demonstration of periodontal skills on a live patient;

4.~~c.~~ A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth;

5.~~d.~~ A demonstration of restorative skills on a mannequin which requires the candidate to complete procedures performed in preparation for a cast restoration~~; and~~

6.~~e.~~ A demonstration of endodontic skills; and~~.~~

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant shall not be eligible for reexamination unless she or he completes additional educational requirements established by the board.

(b)~~2.~~ The department shall consult with the board in planning the times, places, physical facilities, training of personnel, and other arrangements concerning the administration of the examination. The board or a duly designated committee

thereof shall approve the final plans for the administration of the examination.

(c)~~3.~~ If the applicant fails to pass the clinical examination in three attempts, the applicant shall not be eligible for reexamination unless she or he completes additional educational requirements established by the board; and

~~(c) A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant shall not be eligible for reexamination unless she or he completes additional educational requirements established by the board.~~

(d) The board may by rule provide for additional procedures which are to be tested, provided such procedures shall be common to the practice of general dentistry. The board by rule shall determine the passing grade for each procedure and the acceptable variation for examiners. No such rule shall apply retroactively.

The department shall require a mandatory standardization exercise for all examiners prior to each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.

(5)(a) It is the finding of the Legislature that absent a threat to the health, safety, and welfare of the public, the

relocation of applicants to practice dentistry within the geographic boundaries of this state, who are lawfully and currently practicing dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, based on their scores from the American Dental Licensure Examination administered in a state other than this state, is substantially related to achieving the important state interest of improving access to dental care for underserved citizens of this state and furthering the economic development goals of the state. Therefore, in order to maintain valid active licensure in this state, all applicants for licensure who are relocating to this state based on scores from the American Dental Licensure Examination administered in a state other than this state, must actually engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year of receiving such licensure in this state. The Legislature finds that, if such applicants do not actually engage in the full-time practice of dentistry within the geographic boundaries of this state within 1 year of receiving such a license in this state, access to dental care for the public will not significantly increase, patients' continuity of care will not be attained, and the economic development goals of the state will not be significantly met.

(b)1. As used in this section, "full time practice of dentistry within the geographic boundaries of this state within 1 year" is defined as a minimum of 1,200 hours in the initial year of licensure, which must include any combination of the following:

a. Active clinical practice of dentistry providing direct patient care within the geographic boundaries of this state.

b. Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

c. Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

2. The board shall develop rules to determine what type of proof of full-time practice of dentistry within the geographic boundaries of this state for 1 year is required in order to maintain active licensure and shall develop rules to recoup the cost to the board of verifying maintenance of such full-time practice under this section. Such proof must, at a minimum:

a. Be admissible as evidence in an administrative proceeding;

b. Be submitted in writing;

c. Be submitted by the applicant under oath with penalties of perjury attached;

d. Be further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice of dentistry within the

geographic boundaries of this state within the last 365 days; and

e. Include such additional proof as specifically found by the board to be both credible and admissible.

3. The board must make specific findings of fact and conclusions of law regarding the credibility and admissibility of such additional proof as evidence, and such findings and conclusions of law are final agency action under chapter 120. An affidavit of only the applicant is not acceptable proof regarding full-time practice of dentistry within the geographic boundaries of this state within 1 year, unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice within the last 365 days. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath.

(c) It is the further intent of the Legislature that a license issued pursuant to paragraph (a) shall automatically expire and become null, void, revoked, and of no effect in the event the board finds that it did not receive acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license. The board shall make reasonable attempts within 30 days prior to the expiration and revocation of such a license to notify the licensee in writing at his or her last known address of the need for proof of full-time practice in order to continue licensure. If the board has not received a satisfactory response from the

licensee within the 30-day period, the licensee must be served with actual or constructive notice of the pending expiration and revocation of licensure and be given 10 days in which to submit proof required in order to continue licensure. If the 10-day period expires and the board finds it has not received acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license, then the board must issue an administrative order finding that the license has expired and been revoked. It shall be a disciplinary violation, punishable according to s. 466.028, for a licensee under this section to fail to ensure that the board receives acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of such license. The penalty for such violation shall be revocation of licensure. Such an order may be appealed by the former licensee in accordance with the provisions of chapter 120. In the event of expiration and revocation, the licensee shall immediately cease and desist from practicing dentistry and shall immediately surrender to the board the wallet-size identification card and wall card. A person who uses or attempts to use a license issued pursuant to this section which has expired or been revoked commits unlicensed practice of dentistry, a felony of the third degree pursuant to s. 466.026(1)(b), punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 5. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a

reference thereto, subsection (1) of section 466.0065, Florida Statutes, is reenacted to read:

466.0065 Regional licensure examinations.—

(1) It is the intent of the Legislature that schools of dentistry be allowed to offer regional licensure examinations to dental students who are in the final year of a program at an approved dental school for the sole purpose of facilitating the student's licensing in other jurisdictions. This section does not allow a person to be licensed as a dentist in this state without taking the examinations as set forth in s. 466.006, nor does this section mean that regional examinations administered under this section may be substituted for complying with testing requirements under s. 466.006.

Section 6. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a reference thereto, subsections (2), (5), (9), and (12) of section 466.0067, Florida Statutes, are reenacted to read:

466.0067 Application for health access dental license.—The Legislature finds that there is an important state interest in attracting dentists to practice in underserved health access settings in this state and further, that allowing out-of-state dentists who meet certain criteria to practice in health access settings without the supervision of a dentist licensed in this state is substantially related to achieving this important state interest. Therefore, notwithstanding the requirements of s. 466.006, the board shall grant a health access dental license to practice dentistry in this state in health access settings as defined in s. 466.003(14) to an applicant that:

(2) Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee. The fees specified in this subsection may not differ from an applicant seeking licensure pursuant to s. 466.006;

(5) Submits documentation that she or he has completed, or will obtain prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006 for the last full reporting biennium before applying for a health access dental license;

(9) Has never failed the examination specified in s. 466.006, unless the applicant was reexamined pursuant to s. 466.006 and received a license to practice dentistry in this state;

(12) Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a).

Section 7. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a reference thereto, paragraph (d) of subsection (1) of section 466.00671, Florida Statutes, is reenacted to read:

466.00671 Renewal of the health access dental license.—

(1) A health access dental licensee shall apply for renewal each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The board shall renew a health access dental license for an applicant that:

(d) Has not failed the examination specified in s. 466.006 since initially receiving a health access dental license or since the last renewal; and

Section 8. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a reference thereto, paragraph (b) of subsection (2) and subsection (3) of section 466.007, Florida Statutes, are reenacted to read:

466.007 Examination of dental hygienists.—

(2) An applicant shall be entitled to take the examinations required in this section to practice dental hygiene in this state if the applicant:

(b)1. Is a graduate of a dental hygiene college or school approved by the board or accredited by the Commission on Accreditation of the American Dental Association or its successor agency; or

2. Is a graduate of a dental college or school accredited in accordance with s. 466.006(2)(b), or a graduate of an unaccredited dental college or school, and has met the requirements of subsection (3).

(3) A graduate of a dental college or school shall be entitled to take the examinations required in this section to practice dental hygiene in this state if, in addition to the requirements specified in subsection (2), the graduate meets the following requirements:

(a) Submits the following credentials for review by the board:

1. Transcripts totaling 4 academic years of postsecondary dental education; and

2. A dental school diploma which is comparable to a D.D.S. or D.M.D.

Such credentials shall be submitted in a manner provided by rule of the board. The board shall approve those credentials which comply with this paragraph and with rules of the board adopted pursuant to this paragraph. The provisions of this paragraph notwithstanding, an applicant of a foreign dental college or school not accredited in accordance with s. 466.006(2)(b) who cannot produce the credentials required by this paragraph, as a result of political or other conditions in the country in which the applicant received his or her education, may seek the board's approval of his or her educational background by submitting, in lieu of the credentials required in this paragraph, such other reasonable and reliable evidence as may be set forth by board rule. The board shall not accept such other evidence until it has made a reasonable attempt to obtain the credentials required by this paragraph from the educational institutions the applicant is alleged to have attended, unless the board is otherwise satisfied that such credentials cannot be obtained.

(b) Successfully completes one or more courses, of a scope and duration approved and defined by board rule, that meet the requirements of law for instructing health care providers on the human immunodeficiency virus and acquired immune deficiency syndrome. In addition, the board may require an applicant who

graduated from a nonaccredited dental college or school to successfully complete additional coursework, only after failing the initial examination, as defined by board rule, at an educational institution approved by the board or accredited as provided in subparagraph (2)(b)1. A graduate of a foreign dental college or school not accredited in accordance with s. 466.006(2)(b) may not take the coursework set forth in this paragraph until the board has approved the credentials required by paragraph (a).

Section 9. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a reference thereto, subsection (1) of section 466.009, Florida Statutes, is reenacted to read:

466.009 Reexamination.—

(1) The department shall permit any person who fails an examination which is required under s. 466.006 or s. 466.007 to retake the examination. If the examination to be retaken is a practical or clinical examination, the applicant shall pay a reexamination fee set by rule of the board in an amount not to exceed the original examination fee.

Section 10. For the purpose of incorporating the amendment made by this act to section 466.006, Florida Statutes, in a reference thereto, section 466.011, Florida Statutes, is reenacted to read:

466.011 Licensure.—The board shall certify for licensure by the department any applicant who satisfies the requirements of s. 466.006, s. 466.0067, or s. 466.007. The board may refuse

to certify an applicant who has violated any of the provisions of s. 466.026 or s. 466.028.

Section 11. If any provision of this act or its application to any person or circumstance is held invalid by a court of competent jurisdiction, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 12. Except as otherwise specifically provided in this act, this act shall take effect July 1, 2011, and shall not apply retroactively.

T I T L E A M E N D M E N T

Remove the entire title and insert:

A bill to be entitled

An act relating to temporary certificates and licenses for certain health care practitioners; amending s. 456.024, F.S.; providing for issuance of a temporary license to specified health care practitioners who are spouses of active duty members of the Armed Forces under certain circumstances; providing for criminal history checks; providing fees; providing for expiration of a temporary license; requiring a person who is issued a temporary license to be subject to certain general licensing requirements; providing that certain persons are ineligible for such license; providing for revocation of

such license; requiring certain temporary licensees to practice under the indirect supervision of other licensees; amending ss. 458.315 and 459.0076, F.S.; naming the temporary certificates issued to physicians who practice in areas of critical need after Rear Admiral LeRoy Collins, Jr.; amending s. 466.006, F.S.; providing legislative intent with respect to the use of the American Dental Licensure Examination developed by the American Board of Dental Examiners, Inc., in lieu of an independent state-developed practical or clinical exam, to measure an applicant's ability to practice the profession of dentistry; providing for examination fees and use thereof; providing that the American Dental Licensure Examination is not a national examination requiring certification by the Department of Health; revising criteria for applicants for licensure with respect to accreditation of dental school, location of dental school, period of validity of examination scores, time limitation on completion of examination after application, and the filing of specified reports by an applicant; eliminating provisions with respect to applicants who are graduates of a dental college or school not accredited or approved in accordance with the section; adopting the American Dental Licensure Exam as the clinical or practical licensure examination used for licensure as a dentist in this state, providing specified conditions are maintained; providing for period of validity of examination scores; requiring the Board of Dentistry to develop and adopt specified rules;

authorizing applicants to submit American Dental Licensure Examination scores from a jurisdiction outside the state after a specified date; specifying period of validity of such examination scores; providing that authority to submit such examination scores does not apply retroactively; providing that such examination scores outside the period of validity be recognized as valid upon demonstration that the applicant has met specified additional standards; designating the practical examination and specifying minimum standards therefor; requiring applicants for licensure with American Dental Licensure Examination scores from a state other than this state to engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year of receiving such Florida licensure; providing legislative intent with respect thereto; providing a definition; providing legislative intent with respect to expiration and revocation of such licenses upon a finding that acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license was not received by the board; providing procedures and requirements with respect to determination of compliance; providing procedures, requirements, and prohibitions in the event of expiration and revocation; providing a penalty for using or attempting to use a license that has expired or been revoked; providing that the act does not apply retroactively; reenacting ss. 466.0065(1), 466.0067(2),

(5), (9), and (12), 466.00671(1)(d), 466.007(2)(b) and (3), 466.009(1), and 466.011, F.S., relating to regional licensure examinations, application for health access dental license, renewal of the health access dental license, examination of dental hygienists, reexamination, and licensure, respectively, to incorporate the amendments made to s. 466.006, F.S., in references thereto; providing severability; providing effective dates.

CS/CS/HB 479
Horner

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 479 Medical Malpractice
SPONSOR(S): Health & Human Services Access Subcommittee; Civil Justice Subcommittee; Horner and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1590, SB 1892

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	12 Y, 3 N, As CS	Billmeier	Bond
2) Health & Human Services Access Subcommittee	12 Y, 3 N, As CS	Poche	Schoolfield
3) Health Care Appropriations Subcommittee		Clark	Pridgeon
4) Judiciary Committee			

SUMMARY ANALYSIS

This bill makes numerous changes to affect medical malpractice litigation in Florida.

This bill creates an "expert witness certificate" that an expert witness who is licensed in another jurisdiction must obtain before testifying in a medical negligence case or providing an affidavit in the presuit portion of a medical negligence case.

This bill provides for discipline against the license of a physician, osteopathic physician or dentist that provides misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine or the practice of dentistry.

This bill provides for the creation of an informed consent form related to cataract surgery. Such a form is admissible in evidence and its use creates a rebuttable presumption that the physician properly disclosed the risks of cataract surgery.

This bill provides that medical malpractice insurance contracts must contain a clause stating whether the physician or dentist has a right to "veto" any admission of liability or offer of judgment made within policy limits by the insurer. Current law prohibits such provisions in medical malpractice insurance contracts.

This bill provides that records, policies, or testimony of an insurer's reimbursement policies or reimbursement decisions relating to the care provided to the plaintiff are not admissible in any civil action and provides that a health care provider's failure to comply with, or breach of, any federal requirement is not admissible in any medical negligence case.

This bill provides that a plaintiff in a medical negligence action must prove by clear and convincing evidence that the failure of a health care provider to order, perform, or administer supplemental diagnostic tests is a breach of the standard of care.

This bill provides that a defendant or defense counsel in a medical negligence case may interview a claimant's health care providers without notice to the claimant or claimant's counsel. The bill creates an authorization form to allow the defendant access to a claimant's health care providers and medical records.

This bill provides that a hospital is not liable for the negligence of a health care provider with whom the hospital has entered into a contract unless the hospital expressly directs or exercises actual control over the specific conduct which caused the injury.

The bill has an insignificant fiscal impact associated with implementation of the bill, however, the Department of Health can absorb these costs within existing resources.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Overview of Medical Malpractice Litigation

This bill makes changes to numerous statutes relating to medical malpractice litigation. In general, a medical malpractice action proceeds as follows.

- Prior to the filing of a lawsuit, the claimant (the person injured by medical negligence or a party bringing a wrongful death action arising from an incidence of medical malpractice) and defendant (a physician, other medical professional, hospital, or other healthcare facility) are required to conduct "presuit" investigations to determine whether medical negligence occurred and what damages, if any, are appropriate.[1]

- Upon completion of its presuit investigation, the claimant must provide each prospective defendant with a notice of intent to initiate litigation ("presuit notice").[2]

- For a period of 90 days after the presuit notice is mailed to each potential defendant, no lawsuit can be filed and the statute of limitations is tolled.[3] During that time, the parties are required to conduct informal discovery, including the taking of unsworn statements, the exchange of relevant documents, written questions, and an examination of the claimant.[4]

- Upon completion of the presuit investigation and informal discovery process, each potential defendant is required to respond to the claimant and either (1) reject the claim; (2) make a settlement offer; or (3) offer to admit liability and proceed to arbitration to determine damages.[5] At that point, the claimant can either accept the defendant's offer or proceed with the filing of a lawsuit.[6]

- If the case proceeds to trial, economic damages are not capped and noneconomic damages are capped at $1 million recoverable from practitioners and $1.5 million recoverable from nonpractitioners.[7] Damages are apportioned based on comparative fault.[8]

The 2003 Legislation

In 2003, the Legislature adopted ch. 2003-416, L.O.F., in response to dramatic increases in medical malpractice liability insurance premiums and the "functional unavailability" of malpractice insurance for some physicians.[9] The legislation, among other things, created a cap on noneconomic damages, created requirements for expert witness testimony, provided for additional presuit discovery, and required the Office of Insurance Regulation to report yearly on the medical malpractice insurance market in Florida. The reports[10] show the number of closed claims, the amount of damages paid, and

[1] Section 766.203, F.S.
[2] Section 766.106, F.S.
[3] Section 766.106, F.S.
[4] Section 766.205, F.S.
[5] Section 766.106, F.S.
[6] Section 766.106, F.S.
[7] Section 766.118, F.S.
[8] Section 766.112, F.S.
[9] Section 766.201(1), F.S.
[10] Information compiled from the Medical Malpractice Closed Claim Database and Rate Filing Annual Reports created by the Office of Insurance Regulation, 2005-2010. The closed claim and damages information are contained in the "Executive Summary" of each report. These reports can be accessed at http://www.floir.com/DataReports/datareports.aspx

the total gross medical malpractice insurance premium reported to the Office of Insurance Regulation since the enactment of ch. 2003-416, L.O.F.:

Claims, Damages and Insurance Premiums			
Year	Closed Claims	Total Damages	Total Premiums
2004	3,574	$664 million	$860 million
2005	3,753	$677 million	$850 million
2006	3,811	$602 million	$847 million
2007	3,553	$523 million	$663 million
2008	3,336	$519 million	$596 million
2009	3,087	$570 million	$550 million

The Office of Insurance Regulation report summarized the insurance rate filings in 2009:

> On average, rates for companies writing physicians and surgeons' malpractice insurance in the admitted market decreased 8.2%.[11]

The report noted, regarding the decrease in premium:

> This represents a dramatic decrease (36%) in the overall medical malpractice premium reported in Florida in 2009 from what was reported in 2004. This is attributable to the lowering of rates. However, it may also be due to new arrangements by physicians including the use of individual bonding, purchasing malpractice insurance through hospitals/employers as well as utilization of self-insurance funds, or other non-traditional insurance mechanisms.[12]

The report summarized the growth of Florida's medical malpractice insurance market since 2004. In 2009, the Office of Insurance Regulation reported that 22 companies wrote 80% of the direct written premium in medical malpractice insurance and compared that number to prior years:

> This year, achieving the 80% market share requirement again required the inclusion of 22 insurers as in the previous year; 17 were required in the 2007 report, 15 insurers for the 2006 annual report, 12 in the 2005 annual report, and only 11 for the 2004 report.[13]

According to information provided by the Office of State Court Administrator, 1,248 medical malpractice cases were filed in Florida in 2010.

Issues Addressed by the Bill

Presuit Investigation, Presuit Notice, and Presuit Discovery

Background

Section 766.203(2), F.S., requires a claimant to investigate whether there are any reasonable grounds to believe whether any named defendant was negligent in the care and treatment of the claimant and whether such injury resulted in injury to the claimant prior to issuing a presuit notice. The claimant must corroborate reasonable grounds to initiate medical negligence litigation by submitting an affidavit from a medical expert.[14] After completion of presuit investigation, a claimant must send a presuit notice

[11] Florida Office of Insurance Regulation, "2010 Annual Report – October 1, 2010 - Medical Malpractice Financial Information Closed Claim Database and Rate Filings" at page 4.
[12] Florida Office of Insurance Regulation, "2010 Annual Report – October 1, 2010 - Medical Malpractice Financial Information Closed Claim Database and Rate Filings" at page 12.
[13] Florida Office of Insurance Regulation, "2010 Annual Report – October 1, 2010 - Medical Malpractice Financial Information Closed Claim Database and Rate Filings" at page 11.
[14] Section 766.203(2), F.S.

to each prospective defendant.[15] The presuit notice must include a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit.[16] However, the requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions[17] for failure to provide presuit discovery.[18]

Once the presuit notice is provided, no suit may be filed for a period of 90 days. During the 90-day period, the statute of limitations is tolled and the prospective defendant must conduct an investigation to determine the liability of the defendant.[19] Once the presuit notice is received, the parties must make discoverable information available without formal discovery.[20] Informal discovery includes:

1. Unsworn statements - Any party may require other parties to appear for the taking of an unsworn statement.

2. Documents or things - Any party may request discovery of documents or things.

3. Physical and mental examinations - A prospective defendant may require an injured claimant to appear for examination by an appropriate health care provider. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants.

4. Written questions - Any party may request answers to written questions.

5. Medical information release - The claimant must execute a medical information release that allows a prospective defendant to take unsworn statements of the claimant's treating physicians. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.[21]

Section 766.106(7), F.S., provides that a failure to cooperate during the presuit investigation may be grounds to strike claims made or defenses raised. Statements, discussions, documents, reports, or work product generated during the presuit process are not admissible in any civil action and participants in the presuit process are immune from civil liability arising from participation in the presuit process.[22]

At or before the end of the 90 days, the prospective defendant must respond by rejecting the claim, making a settlement offer, or making an offer to arbitrate in which liability is deemed admitted, at which point arbitration will be held only on the issue of damages.[23] Failure to respond constitutes a rejection of the claim.[24] If the defendant rejects the claim, the claimant can file a lawsuit.

Effect of the Bill

This bill allows the court to impose sanctions for a claimant's failure to provide the list of health care providers required by statute.

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[15] Section 766.166(2)(a), F.S.
[16] Section 766.106(2)(a), F.S.
[17] Sanctions can include the striking of pleadings, claims, or defenses, the exclusion of evidence, or, in extreme cases, dismissal of the case.
[18] Section 766.106(2)(a), F.S.
[19] Section 766.106(3), (4), F.S.
[20] Section 766.106(6)(a), F.S. The statute also provides that failure to make information available is grounds for dismissal of claims or defenses.
[21] Section 766.106(6), F.S.
[22] Section 766.106(5), F.S.
[23] Section 766.106(3)(b), F.S.
[24] Section 766.106(3)(c), F.S.

This bill amends s. 766.106(5), F.S., to provide that immunity from civil liability does not prevent the Department of Health from taking disciplinary action against a physician that provides a false, misleading, or deceptive expert opinion during the presuit process.

Ex Parte Interviews with Physicians by Defense Counsel

Background

In many civil cases, counsel for any party can meet with any potential witness who is willing to speak without notice to the opposing counsel. In 1984, the Florida Supreme Court ruled that there was no common law or statutory privilege of confidentiality as to physician-patient communications[25] and that there was no prohibition on defense counsel communicating with a claimant's physicians. In 1988, the Legislature enacted a statute to create a physician-patient privilege.[26] The current version of the statute provides, in relevant part:

> Except as otherwise provided in this section and in s. 440.13(4)(c), [patient medical records] may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient.[27]

The statute provides some exceptions to the confidentiality in medical malpractice cases but the Florida Supreme Court has ruled that defense counsel are barred by the statute from having an ex parte conference with a claimant's current treating physicians.[28]

The Governor's Select Task Force on Healthcare Professional Liability Insurance noted problems caused by the inability of defense counsel to interview a claimant's treating physicians:

> [T]he defendant is frequently in the position of having to investigate the plaintiff's medical history or current condition in order to discover other possible causes of the plaintiff's injury that could be used in defending the action. In addition, this information is often useful in determining the strength of the plaintiff's case, which the defendant could use to decide whether to settle the claim or proceed to trial. It is often necessary to interview several of the plaintiff's treating healthcare providers in order to acquire this information. But, because formal discovery is an expensive and time consuming process, defendants are often unable to adequately gather this information in preparation of their defense.[29]

Opponents of allowing defendants access to ex parte interviews with treating physicians argued the system was not broken. The report continued:

> The problem the Legislature corrected was the private, closed-door meetings between insurance adjusters, defense lawyers, and the person being sued. Typically, the person being sued would speak with his or her colleagues and say "I need your help here. I'm getting sued. I need you to help me out on either the causation issue or the liability issue or the damage issue".
>
> The present system is not broken. Crafting language to go back prior to 1988, to allow unfettered access, is not appropriate. To allow a situation where a defense lawyer or an

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[25] See *Coralluzzo v. Fass*, 671 So. 2d 149 (Fla. 1984),
[26] Chapter 88-208, Laws of Florida
[27] Section 456.057(7)(a), F.S.
[28] *See Acosta v. Richter*, 671 So. 2d 149 (Fla. 1996).
[29] Report of the Governor's Select Task Force on Healthcare Professional Liability Insurance (2003) at p. 231. The Report can be accessed at www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf

insurance adjuster and the doctor go to see a patient's treating physician on an informal basis would further drive a wedge between that physician and the patient."[30]

In 2003, the Legislature amended s. 706.106, F.S., to require a claimant to execute a medical information release to allow prospective defendants to take unsworn statements of the claimant's treating physician on issues relating to the personal injury or wrongful death during the presuit process. The claimant and counsel are entitled to notice, an opportunity to be heard, and to attend the taking of the statement. The legislation did not provide for ex parte interviews by defense counsel with a claimant's treating physicians.[31]

Effect of the Bill

This bill provides that a prospective defendant or his or her legal representative may interview the claimant's treating health care providers without notice or the presence of the claimant or the claimant's legal representative.

This bill also makes changes to the presuit provision relating to unsworn statements. It removes the provision requiring a claimant to execute a medical release from s. 766.106, F.S., and creates a new release provision.

This bill requires a claimant to execute an "authorization for release of protected health information" and include it with the presuit notice of intent to initiate litigation. The form is provided in the bill and authorizes the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The bill provides that the presuit notice is void if it is not accompanied by the executed authorization form. It further provides that the presuit notice is retroactively void from the date of issuance if the authorization is revoked and that "any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void."

Specifically, the form that claimants are required to execute provides that representatives of the potential defendant may obtain and disclose information from health care providers for facilitating the investigation and evaluation of the medical negligence claim described in the presuit notice or defending against any litigation arising out of the medical negligence claim made on the basis of the presuit notice.

The form informs the claimant of the type of health information that may be obtained by defendants and defendant's counsel and from whom that information can be obtained. The form informs claimants of the extent of the authorization, that the authorization expires upon the resolution of the claim, that executing the authorization is not a condition of continued treatment, and that the claimant has the right to revoke the authorization at any time. The form has a section where claimants can list health providers to which the authorization does not apply. The claimant must certify that such health care information is not potentially relevant to the claim.

The language in the authorization form set forth in the bill appears to comply with federal requirements. In recent years, courts have been dealing with the effect of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") on state medical malpractice litigation. The HIPAA privacy rules prohibit the disclosure of protected health information except in specified circumstances.[32] With limited exceptions, HIPAA's privacy rules preempt any contrary requirement of state law unless the state law is more stringent than the federal rules.[33]

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[30] Report of the Governor's Select Task Force on Healthcare Professional Liability Insurance (2003) at p. 233 (internal footnotes omitted).
[31] Chapter 2003-416, Laws of Florida
[32] 45 C.F.R. s. 164.502
[33] 45 C.F.R. s. 160.203

HIPAA rules permit disclosure of health information in a number of circumstances.[34] Health care information may be disclosed if the patient has executed a valid written authorization.[35]

States with statutory provisions that allow for ex parte interviews with claimant's physicians have had to determine whether HIPAA preempted state laws allowing such interviews. Some courts have held that state laws permitting ex parte interviews violate HIPAA.[36] Other courts have held that HIPAA does not prohibit such interviews.[37] Texas dealt with the issue by enacting a law that required a claimant to execute a form authorizing the release of health information. The Texas Supreme Court held that the authorization form complied with the HIPAA requirements.[38] The court specifically rejected the argument that the authorization was not freely given because it was a requirement to proceed with a lawsuit:

> First, while it is true that the [claimants] could not have proceeded with their suit if [the injured person] had not executed the authorization, it was their choice to file the suit in the first instance. Moreover, on several occasions, courts have ordered plaintiffs to execute authorizations compliant with section 164.508.
>
> HIPAA preempts state law only if it would be impossible for a covered entity to comply with both the state and federal requirement, or if it would undermine HIPAA's purposes. While several courts have held that HIPAA preempts state law procedures that would allow ex parte contacts between health care providers and defendants and their representatives, none of them involve situations in which the patient has executed a written release compliant with 45 C.F.R. s. 164.508. Because [the Texas statute at issue] authorizes disclosure under the exact same terms as 45 C.F.R. s. 164.508, it would not be impossible for a health care provider to comply with both laws. Moreover, while the privacy of medical information is the primary goal of the privacy rules, the rules balance that interest against other important needs. Reducing the costs of medical care is a concern underlying both HIPAA and [the Texas statute]. In this case, the legislatively prescribed form authorizes disclosure only to the extent the information would "facilitate the investigation and evaluation" or defense of the health care claim described in the [claimants'] notice. Accordingly, under the circumstances presented, we conclude that HIPAA does not preempt [the Texas statute].[39]

The language in the authorization form in the bill is substantially similar to the language approved by the Texas Supreme Court. This bill also expands the court's authority to dismiss a claim and assess fees if the authorization form is not completed in good faith.

Expert Witness Qualifications

Background

Florida law requires expert witnesses in medical negligence cases to meet certain qualifications. The witness must be a licensed health care provider. If the health care provider against whom or on whose behalf the testimony[40] is offered is a specialist, the expert witness must:

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[34] Circumstances in which health information may be disclosed include in a judicial proceeding, protected information may be disclosed in response to a court order. It may also be disclosed without a court order in response to a subpoena or discovery request if the health care provider receives satisfactory assurances that the requestor has made reasonable efforts to ensure that the subject of the information has been given notice of the request. *See* 45 C.F.R. s. 164.512(3)(1)(i), 45 C.F.R. s. 164.512(e)(1)(ii)(A).

[35] 45 C.F.R. s. 164.508

[36] *See Law v. Zuckerman*, 307 F.Supp.2d 705 (D. Maryland 2004); *Moreland v. Austin*, 670 S.E.2d 68 (Georgia 2008).

[37] *See Holmes v. Nightingale*, 158 P.3d 1039 (Oklahoma 2007).

[38] *In re: Collins*, 286 S.W.3d 911 (Tex. 2009)

[39] *In re: Collins*, 286 S.W.3d 911, 920 (Tex. 2009)(internal citations omitted).

[40] Section 766.102, F.S., provides qualifications for expert witnesses testifying at trial. Sections 766.202(6) and 766.203, F.S., provide qualifications for expert witnesses that must provide presuit corroboration of negligence claims. The qualifications for trial experts and presuit experts are the same.

(1) Specialize in the same or similar specialty as the health care provider against whom or on whose behalf the testimony is offered and

(2) Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.[41]

If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must:

(1) Have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice or consultation as a general practitioner;

b. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

c. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.[42]

If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must:

(1) Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;

b. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

c. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.[43]

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[41] Section 766.102(5), F.S.
[42] Section 766.102(5), F.S.
[43] Section 766.102(5), F.S.

Chapter 458, F.S., governs the regulation of medical practice. Chapter 459, F.S., governs the regulation of osteopathic medicine. Chapter 466, F.S., governs the regulation of dentists. Each chapter creates a board to deal with issues relating to licensing and discipline of physicians, osteopathic physicians and dentists. Under current law, an expert witness is not required to possess a Florida license to practice medicine, osteopathic medicine or dentistry.[44]

Effect of the Bill

This bill requires 3 years of "professional time" that an expert witness must have devoted to active practice, clinical research, or instruction of students if the expert is to provide testimony against a specialist or health care provider other than a specialist or general practitioner. The bill will make the "professional time" requirement the same for all three categories of expert witnesses.

The bill requires the Department of Health to issue an "expert witness certificate" to a physician or dentist licensed in another state or Canada to provide expert witness testimony in this state. The bill requires the Department to issue the certificate if the physician, osteopathic physician or dentist submits a completed application, pays an application fee of $50, and has not had a previous expert witness certificate revoked by the appropriate board. The application must contain the physician's or dentist's legal name; mailing address, telephone number, and business locations; the names of jurisdictions where the physician or dentist holds an active and valid license; and the license numbers issued to the physician or dentist by other jurisdictions.

The department must approve or deny the certificate within seven business days after receipt of the application and payment of the fee or the application is approved by default. A physician or dentist must notify the appropriate department of his or her intent to rely on a certificate approved by default. The certificate is valid for two years.

The certificate authorizes a physician, osteopathic physician or dentist to provide a verified expert opinion in the presuit stage of a medical malpractice case and to provide testimony about the standard of care in medical negligence litigation. The certificate does not authorize the physician, osteopathic physician or dentist to practice medicine or dentistry and does not require the certificate holder to obtain a license to practice medicine or dentistry.

This bill amends s. 766.102, F.S., relating to the qualifications of expert witness in cases against physicians licensed under ch. 458 or ch. 459, F.S, or dentists licensed under ch. 466, F.S. The bill requires that the expert witness testifying about the standard of care in such cases must be licensed under ch. 458, F.S., ch. 459, F.S., or ch. 466, F.S., or possess a valid expert witness certificate.

This bill also amends s. 766.102(5), F.S., to require that an expert witness conduct a complete review of the pertinent medical records before the witness can give expert testimony.

License Disciplinary Actions

Background

Chapter 458, F.S., regulates medical practice. Chapter 459, F.S., regulates the practice of osteopathic medicine. Chapter 466, F.S., regulates the practice of dentistry. Each chapter creates a board to deal with issues relating to discipline of physicians, osteopathic physicians and dentists. In general, the discipline process under ch. 458, F.S., ch. 459, F.S., and ch. 466, F.S., begins when a complaint is filed against a health care provider alleging a violation of the disciplinary statutes. The Department of Health reviews the case and a department prosecutor presents the case to the appropriate board or probable cause panel of the appropriate board. If probable cause is found, the Department of Health files an administrative complaint. If the health care provider disputes the allegations of the complaint,

[44] *See Baptist Medical Center of the Beaches, Inc. v. Rhodin*, 40 So. 3d 112, 117 (Fla. 1st DCA 2010)(noting that Florida's expert witness statute "does not encompass a universe limited only to Florida licensees").

the provider can request a hearing before an administrative law judge. An attorney for the Department of Health prosecutes the case and the provider may be represented by counsel. The administrative law judge issues a recommended order upon the conclusion of the hearing. The recommended order and any exceptions filed by the parties are considered by the appropriate board and the board determines the appropriate discipline which can include a fine, suspension of the license, or revocation of the license.[45]

Sections 456.072, 458.331, 459.015 and 466.028, F.S., create grounds for which disciplinary action may be taken against a licensee.[46] It is not clear from those statutes whether the boards can impose discipline against a licensee for providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine, osteopathic medicine or dentistry. "Statutes providing for the revocation or suspension of a license to practice are deemed penal in nature and must be strictly construed, with any ambiguity interpreted in favor of the licensee."[47] Section 458.331(1)(k), F.S., provides the following ground for discipline:

> Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.[48]

Section 466.028(1)(l), F.S., provides the following ground for discipline:

> Making deceptive, untrue, or fraudulent representations in or related to the practice of dentistry.

It is not clear whether a court would find deceptive or untrue expert testimony in a medical negligence case to be "related to the practice" of medicine, osteopathic medicine or dentistry.[49]

Current law allows discipline against a licensee for "being found by any court in this state to have provided corroborating written medical expert opinion attached to any statutorily required notice of claim or intent or to any statutorily required response rejecting a claim, without reasonable investigation."[50]

Effect of the Bill

The bill amends ss. 458.331, 459.015 and 466.028, F.S., to provide that the appropriate board may impose discipline on a physician or osteopathic physician who provides "misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine" or on a dentist who provides "misleading, deceptive, or fraudulent expert witness testimony related to the practice of dentistry." The disciplinary statutes allow the board to impose discipline against licensees who violate the statutes. The bill provides that an expert witness certificate shall be treated as a license in any disciplinary action and that the holder of an expert witness certificate is subject to discipline by the appropriate board.

The bill also amends ss. 458.331, 459.015 and 466.028, F.S., to provide that the purpose of the disciplinary sections is to "facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference."

Incorporation by Reference

Background

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[45] *See* ss. 456.072 and 456.073, F.S.

[46] Section 456.072(2), F.S., deals with discipline against licensees.

[47] *Elmariah v. Board of Medicine*, 574 So. 2d 164, 165 (Fla. 1st DCA 1990).

[48] Section 459.015(1)(m), F.S., contains the same language related to osteopathic physicians.

[49] In *Elmariah*, 574 So. 2d at 165, the court held that a deceptive application for staff privileges at a hospital was not made "in" the practice of medicine but noted that such an application might be "related" to the practice of medicine. The case demonstrates how a court will construe a statute very strictly in favor of the licensee.

[50] *See* ss. 458.331(1)(jj) and 459.015(1)(mm), F.S.

Current law allows for one section of statute to reference another, or "incorporation by reference." This is commonly done to prevent the repetition of a particular text. There are two kinds of references. A "specific reference" incorporates the language of the statute referenced and becomes a part of the new statute even if the referenced statute is later altered or repealed. The law presumes that the Legislature intends to incorporate the text of the current law as it existed when the reference was created. A law review article explained:

> From a very early time, it has been generally agreed that the legal effect of a specific statutory cross reference is to incorporate the language of the referenced statute into the adopting statute as though set out verbatim, and that in the absence of express legislative intent to the contrary, the Legislature intends that the incorporation by reference shall not be affected by a subsequent change to the referenced law – even its repeal. In other words, each referenced provision has two separate existences – as substantive provision and as an incorporation by reference – and neither is thereafter affected by anything that happens to the other.[51]

The second type of referenced statute is a "general reference." The general reference differs from the specific reference in that it presumes that the referenced section may be amended in the future, and any such changes are permitted to be incorporated into the meaning of the adopting statute. Again, Means explained in his article that "when the reference is not to a specific statute, but to the law in general as it applies to a specified subject, the reference takes the law as it exists at the time the law is applied. Thus, in cases of general references, the incorporation does include subsequent changes to the referenced law."[52]

Currently, other provisions of statutes provide statutory intent which allow for references to that statute to be construed as a general reference under the doctrine of incorporation by reference. For example, the statutes which deal with the punishments for criminal offenses contain clauses which allow for any reference to them to constitute a general reference.[53] This means that any time the Legislature amends a criminal offense, these punishment statutes do not have to be reenacted within the text of a bill because it is understood that their text or interpretation may change in the future.

Effect of the Bill

This bill contains a provision providing that the changes to the disciplinary statutes constitute a general reference under the doctrine of incorporation by reference. The incorporation by reference language in this bill could be interpreted to allow amendments to statutes which reference the disciplinary statute so that the reference takes the law as it exists at the time the law is applied.

Informed Consent

Background

The Mayo Clinic website describes cataract surgery as follows:

> Cataract surgery is a procedure to remove the lens of your eye and, in most cases, replace it with an artificial lens. Cataract surgery is used to treat a cataract — the clouding of the normally clear lens of your eye.[54]

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[51] Earnest Means, "Statutory Cross References - The "Loose Cannon" of Statutory Construction," Florida State University Law Review, Vol. 9, p. 3 (1981).
[52] Earnest Means, "Statutory Cross References - The "Loose Cannon" of Statutory Construction," Florida State University Law Review, Vol. 9, p. 3 (1981).
[53] *See* ss. 775.082, 775.083, and 775.084, F.S.
[54] http://www.mayoclinic.com/health/cataract-surgery/MY00164 (accessed February 19, 2011).

Complications after cataract surgery are uncommon and risks include inflammation, infection, bleeding, swelling, retinal detachment, glaucoma, or a secondary cataract.[55]

The doctrine of informed consent requires a physician to advise his or her patient of the material risks of undergoing a medical procedure.[56] Physicians and osteopathic physicians are required to obtain informed consent of patients before performing procedures and are subject to discipline for failing to do so.[57] Florida has codified informed consent in the "Florida Medical Consent Law," s. 766.103, F.S. Section 766.103(3), F.S., provides:

> (3) No recovery shall be allowed in any court in this state against [specified health care providers including physicians and osteopathic physicians] in an action brought for treating, examining, or operating on a patient without his or her informed consent when:
>
> (a)1. The action of the [health care provider] in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and
>
> 2. A reasonable individual, from the information provided by the [health care provider], under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other [health care providers] in the same or similar community who perform similar treatments or procedures; or
>
> (b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the [health care provider] in accordance with the provisions of paragraph (a).

Section 766.103(4), F.S., provides:

> (4)(a) **A consent which** is evidenced in writing and **meets the requirements of subsection (3) shall**, if validly signed by the patient or another authorized person, **raise a rebuttable presumption of a valid consent.**
>
> (b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent. (emphasis added).

The Florida Supreme Court discussed the effect of the rebuttable presumption in the Medical Consent Law in *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596 (Fla. 1987). In that case, the patient signed two consent forms, one acknowledging that no guarantees had been made concerning the results of the operation and one stating that the surgery had been explained to her.[58] The patient argued that the doctor made oral representations that contradicted the consent forms and made other statements that were not addressed by the consent forms. The court found that such claims could overcome the presumption:

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[55] http://www.mayoclinic.com/health/cataract-surgery/MY00164/DSECTION=risks (accessed February 19, 2011).
[56] *See State v. Presidential Women's Center*, 937 So. 2d 114, 116 (Fla. 2006)("The doctrine of informed consent is well recognized, has a long history, and is grounded in the common law and based in the concepts of bodily integrity and patient autonomy").
[57] *See* s. 458.331, F.S., and 459.015, F.S.
[58] *See Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 598 (Fla. 1987).

> [W]e note that no conclusive presumption of valid consent, rebuttable only upon a showing of fraud, will apply to the case. The alleged oral warranties, of course, if accepted by the jury may properly rebut a finding of valid informed consent.[59]

A second issue in Valcin was not related to informed consent but was which type of presumption should apply when surgical records related to the surgery at issue were lost. The *Valcin* court discussed the two types of presumptions created under the Evidence Code:

> At this point, we should clarify the type of rebuttable presumption necessitated under this decision. The instant problem should be resolved either by applying a shift in the burden of producing evidence, section 90.302(1), Florida Statutes (1985), or a shift in the burden of proof. § 90.302(2), Fla.Stat. (1985). While the distinction sounds merely technical, it is not. In the former, as applied to this case, the hospital would bear the initial burden of going forward with the evidence establishing its nonnegligence. If it met this burden by the greater weight of the evidence, the presumption would vanish, requiring resolution of the issues as in a typical case. *See Gulle v. Boggs,* 174 So.2d 26 (Fla.1965); C. Ehrhardt, *Florida Evidence* § 302.1 (2d ed. 1984). The jury is never told of the presumption.
>
> In contrast, once the burden of proof is shifted under section 90.302(2), the presumption remains in effect even after the party to whom it has been shifted introduces evidence tending to disprove the presumed fact, and "the jury must decide whether the evidence introduced is sufficient to meet the burden of proving that the presumed fact did not exist." Ehrhardt at § 302.2, citing *Caldwell v. Division of Retirement,* 372 So. 2d 438 (Fla. 1979).[60]

The *Valcin* court discussed the second kind of rebuttable presumption:

> The second type of rebuttable presumption, as recognized in s. 90.302(2), F.S., affects the burden of proof, shifting the burden to the party against whom the presumption operates to prove the nonexistence of the fact presumed. "When evidence rebutting such a presumption is introduced, the presumption does not automatically disappear. It is not overcome until the trier of fact believes that the presumed fact has been overcome by whatever degree of persuasion is required by the substantive law of the case." Rebuttable presumptions which shift the burden of proof are "expressions of social policy," rather than mere procedural devices employed "to facilitate the determination of the particular action."
>
> A section 90.302(2) presumption shifts the burden of proof, ensuring that the issue of negligence goes to the jury.[61] (internal citations omitted).

Effect of the Bill

The bill requires that the Boards of Medicine and Osteopathic Medicine to adopt rules establishing a standard informed consent form setting forth recognized specific risks relating to cataract surgery. The boards must consider information from physicians and osteopathic physicians regarding specific recognized risks of cataract surgery and must consider informed consent forms used in other states.

The rule must be proposed within 90 days of the effective date of the bill and the provisions of s. 120.541, F.S., relating to adverse impacts, estimated regulatory costs, and legislative ratification of rules do not apply.

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[59] *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 599 (Fla. 1987).
[60] *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 600 (Fla. 1987).
[61] *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 600-601 (Fla. 1987).

The bill provides that in a civil action or administrative proceeding against a physician or osteopathic physician based on the failure to properly disclose the risks of cataract surgery, a properly executed informed consent form is admissible and creates a rebuttable presumption that the physician or osteopathic physician properly disclosed the risks. The bill requires that the rebuttable presumption be included in the jury instruction in a civil action.

Reports of Adverse Incidents

Current Law

Sections 458.351 and 459.026, F.S., require health care providers practicing in an office setting to report "adverse incidents" to the Department of Health and requires the Department of Health to review such incidents to determine whether disciplinary action is appropriate. Hospitals and other facilities licensed under s. 395.0197, F.S., also have adverse incident reporting requirements. In general, adverse incidents are incidents resulting in death, brain or spinal damage, wrong site surgical procedures, or cases of performing the wrong surgical procedure.[62]

Effect of the Bill

The bill provides that incidents resulting from recognized specific risks described in the signed consent forms (discussed elsewhere in this analysis) related to cataract surgery are not considered adverse incidents for purposes of ss. 458.351, 459.026, and 395.0197, F.S.

"Consent to Settle" Clauses in Medical Malpractice Insurance Contracts

Background

Section 627.4147, F.S., contains provisions relating to medical malpractice insurance contracts. Among other things, medical malpractice insurance contracts must include a clause requiring the insured to cooperate fully in the presuit review process if a notice of intent to file a claim for medical malpractice is made against the insured.

In addition, the insurance contract must include a clause authorizing the insurer or self-insurer to "determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits."[63] The statute further provides that it is against public policy for any insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration, settlement offer, or offer of judgment, when such offer is within the policy limits. However, the statute provides that the insurer must act in good faith and in the best interests of the insured.[64]

The provision giving insurers the exclusive right to settle claims within policy limits was enacted in 1985.[65] Subsequent to that legislation, there have been causes where physicians argued that insurance companies improperly settled claims.[66] In *Rogers v. Chicago Insurance Company*, 964 So. 2d 280 (Fla. 4th DCA 2007), a physician sued his malpractice carrier for failing to exercise good faith in settling a claim. He argued that the claim was completely defensible and he was damaged by the settlement because of, among other things, his inability to obtain medical malpractice insurance.[67] The court held that the statute did not create a cause of action for the physician and explained:

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[62] *See generally* s. 458.351, F.S., for examples of incidents required to be reported. Sections 459.026 and 395.0197, F.S., contain reporting requirements for osteopathic physicians and hospitals.
[63] Section 627.4147(1)(b)1., F.S.
[64] Section 627.4147(1)(b)1., F.S.
[65] *See Shuster v. South Broward Hosp. Dist. Physicians' Professional Liability Ins. Trust*, 591 So. 2d 174, 176 n. 1 (Fla. 1992).
[66] In addition to the case discussed in this analysis, see *Freeman v. Cohen*, 969 So. 2d 1150 (Fla. 4th DCA 2008).
[67] *See Rogers v. Chicago Ins. Co.*, 964 So. 2d 280, 281 (Fla. 4th DCA 2007).

> Roger's interpretation of the statute would make its primary purpose, which is not to allow insured's to veto malpractice settlements, meaningless. We say that because, if an insurer did settle with the claimant over the objection of the insured, the insurer would then be exposed to unlimited damages for increased insurance premiums, inability to get insurance, or other far removed and unknown collateral damages. No insurer would take that risk and the objecting insured would thus have the veto which the statute purports to eliminate.
>
> We conclude that the statutory language, requiring that any settlement be in the best interests of the insured, means the interests of the insured's rights under the policy, not some collateral effect unconnected with the claim. For example, the insured may have a counterclaim in the malpractice lawsuit for services rendered, which should not be ignored. Nor should the insurer be able to settle with the claimant and leave the doctor exposed to a personal judgment for contribution by another defendant in the same case. By including the language that any settlement must be in the best interest of the insured, the legislature was merely making it clear that, although it was providing that an insured cannot veto a settlement, the power to settle is not absolute and must still be in the best interests of the insured[.][68]

In dissent, Judge Warner argued that the majority effectively writes the "good faith" provision out of the statute:

> The majority suggests that Rogers's interpretation would render meaningless part of the statute in that an insured could veto malpractice settlements by objecting. I do not agree. If the insurer has fulfilled its obligation of good faith in investigating and evaluating the case, and it has considered the best interests of the insured, then it can settle the case. The insured cannot veto the settlement...
>
> The statutory obligation of good faith and best interest provides the only protection to a doctor against insurance companies who may settle unfounded cases simply because it is cheaper to settle than to defend. That is a decision in the insurer's own interests, which it could do under *Shuster* but is not consistent, in my view, with its duties under section 627.4147. The majority opinion takes this statutory protection away from the physician. I would read the statute as written and allow Dr. Rogers's cause of action to proceed[.][69]

Effect of the Bill

This bill allows medical malpractice insurance policies to contain provisions allowing physicians to "veto" settlement offers made to the insurance company that are within policy limits. Instead of not allowing such provisions, the bill would require that policies "clearly" state whether the physician has the exclusive right to veto settlements.

Standard of Proof in Cases Relating to Supplemental Diagnostic Tests

Background

Section 766.102(4), F.S., provides that the "failure of a health care provider to order, perform, or administer supplemental diagnostic tests shall not be actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care."

Section 766.102, F.S., provides that a claimant in a medical negligence action must prove by "the greater weight of the evidence" that actions of the health care provider represented a breach of the

[68] *Rogers v. Chicago Ins. Co.*, 964 So. 2d 280, 284 (Fla. 4th DCA 2007).
[69] *Rogers v. Chicago Ins. Co.*, 964 So. 2d 280, 285-286 (Fla. 4th DCA 2007)(Warner, J., dissenting).

prevailing professional standard of care. Greater weight of the evidence means the "more persuasive and convincing force and effect of the entire evidence in the case."[70]

Other statutes, such as license disciplinary statutes, require a heightened standard of proof called "clear and convincing evidence." Clear and convincing evidence has been described as follows:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.[71]

Section 766.111, F.S., prohibits a health care provider from ordering, procuring, providing, or administering unnecessary diagnostic tests.

Effect of the Bill

The bill provides that the claimant in a medical negligence case where the death or injury resulted from a failure of a health care provider to order, perform, or administer supplemental diagnostic tests must prove that the health care provider breached the standard of care by clear and convincing evidence. This bill would have the effect of making such claims more difficult to prove. Standards of proof in other medical negligence cases would remain unchanged.

Exclusion of Evidence

Background

Section 90.402, F.S., provides that all relevant evidence is admissible, except as a provided by law. Section 90.401, F.S, defines "relevant evidence" as evidence tending to prove or disprove a material fact. The trial court judge determines whether evidence is admissible at trial and a decision on the admissibility is reviewable for an abuse of discretion.

Currently, information about whether an insurer reimbursed a physician for performing a particular procedure or test is subject to admission as evidence during a trial based on whether it is relevant. The trial judge makes an individual determination as to whether such evidence is admissible.

Effect of the Bill

The bill amends s. 766.102, F.S., to provide that records, policies, or testimony of an insurer's[72] reimbursement policies[73] or reimbursement determination regarding the care provided to the plaintiff are not admissible as evidence in medical negligence actions.

The bill amends s. 766.102, F.S., to provide that a health care provider's failure to comply with, or breach of, any federal requirement is not admissible as evidence in any medical negligence case. Evidence of a health care provider's compliance with federal requirements could be admissible if the trial judge found it to be relevant.

Hospital Liability for Independent Contractors

Background

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[70] *Castillo v. E.I. Du Pont De Nemours & Co., Inc.*, 854 So. 2d 1264, 1277 (Fla. 2003)

[71] *Inquiry Concerning Davey*, 645 So. 2d 398, 404 (Fla. 1994)(quoting *Slomowitz v. Walker*, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

[72] The bill defines "insurer" as "any public or private insurer, including the Centers for Medicare and Medicaid Services."

[73] The bill defines "reimbursement policies" as "an insurer's policies and procedures

The Florida Supreme Court has described the doctrine of vicarious liability:

> The concept of vicarious liability can be described as follows: "A person whose liability is imputed based on the tortuous acts of another is liable for the entire share of comparative responsibility assigned to the other." Vicarious liability is often justified on the policy grounds that it ensures that a financially responsible party will cover damages. Thus, the vicariously liable party is liable for the entire share of the fault assigned to the active tortfeasor. The vicariously liable party has not breached any duty to the plaintiff; its liability is based solely on the legal imputation of responsibility for another party's tortuous acts. The vicariously liable party is liable only for the amount of liability apportioned to the tortfeasor. In sum, the doctrine of vicarious liability takes a party that is free of legal fault and visits upon that party the negligence of another.[74]

Generally, a hospital may not be held liable for the negligence of independent contractor physicians to whom it grants staff privileges.[75] "Vicarious liability does not therefore necessarily attach to the hospital for the doctors' acts or omissions."[76] One court has explained:

> While some hospitals employ their own staff of physicians, others enter into contractual arrangements with legal entities made up of an association of physicians to provide medical services as independent contractors with the expectation that vicarious liability will not attach to the hospital for the negligent acts of those physicians.[77]

However, a hospital may be held vicariously liable for the acts of independent contractor physicians if the physicians act with the apparent authority of the hospital.[78] Apparent authority exists only if all three of the following elements are present: (a) a representation by the purported principal; (b) a reliance on that representation by a third party; and (c) a change in position by the third party in reliance on the representation.[79]

There are numerous cases in Florida appellate courts where courts have struggled over the issue of whether the hospital should be liable for the negligence of an independent contractor physician. Some cases involve the apparent authority issue. Others involve the issue of whether the hospital has a nondelegable duty to provide certain medical services. One court found:

> Even where a physician is an independent contractor, however, a hospital that "undertakes by [express or implied] contract to do for another a given thing" is not allowed to "escape [its] contractual liability [to the patient] by delegating performance under a contract to an independent contractor."[80]

One argument in favor of imposing such a duty on hospitals is:

> This trend suggests that hospitals should be vicariously liable as a general rule for activities within the hospital where the patient cannot and does not realistically have the ability to shop on the open market for another provider. Given modern marketing approaches in which hospitals aggressively advertise the quality and safety of the services provided within their hospitals, it is quite arguable that hospitals should have a nondelegable duty to provide adequate radiology departments, pathology laboratories, emergency rooms, and other professional services necessary to the ordinary and usual

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[74] *American Home Assur. Co. v. National Railroad Passenger Corp.*, 908 So. 2d 459, 467-468 (Fla. 2005)(internal citations omitted).
[75] *See Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989).
[76] *Pub. Health Trust of Dade County v. Valcin*, 507 So. 2d 596, 601 (Fla. 1987).
[77] *Roessler v. Novak*, 858 So. 2d 1158, 1162 (Fla. 2d DCA 2003).
[78] *See Stone v. Palms West Hosp.*, 941 So. 2d 514 (Fla. 4th DCA 2006).
[79] *See Roessler v. Novak*, 858 So. 2d 1158, 1161 (Fla. 2d DCA 2003).
[80] *Shands Teaching Hosp. and Clinic, Inc. v. Juliana*, 863 So. 2d 343, 349 n. 9 (Fla. 1st DCA 2003). *But see Jones v. Tallahassee Memorial Regional Healthcare, Inc.* 923 So. 2d 1245 (Fla. 1st DCA 2006)(refusing to extend the nondelegable duty doctrine to physicians).

> functioning of the hospital. The patient does not usually have the option to pick among several independent contractors at the hospital and has little ability to negotiate and bargain in this market to select a preferred radiology department. The hospital, on the other hand, has great ability to assure that competent radiologists work within an independent radiology department and to bargain with those radiologists to provide adequate malpractice protections for their mutual customers. I suspect that medical economics would work better if the general rule placed general vicarious liability upon the hospital for these activities.[81]

In March 2003, the Florida Supreme Court issued its opinion in *Villazon v. Prudential Health Care Plan*, 843 So. 2d 842 (Fla. 2003). In *Villazon*, the court considered whether vicarious liability theories could make an HMO liable for the negligence of a physician who had a contract with the HMO. The court held that the HMO Act did not provide a cause of action against the HMO for negligence of the physician but that a suit could proceed under common law theories of negligence under certain circumstances.[82] It noted that the "existence of an agency relationship is normally one for the trier of fact to decide."[83] The court explained that the physician's contractual independent contractor status does not alone preclude a finding of agency and remanded the case for consideration of whether the insurer exercised sufficient control over the physician's actions such that an agency relationship existed or whether agency could be established under an apparent agency theory.[84]

Subsequent to *Villazon*, the Legislature passed ch. 2003-416, L.O.F., which created s. 768.0981, F.S. Section 768.0981, F.S., provides:

> An entity licensed or certified under chapter 624, chapter 636, or chapter 641[85] shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

The statute provides that insurers, HMOs, prepaid limited health service organizations, and prepaid health clinics are not liable for the negligence of health care providers with whom the entity has a contract unless the entity expressly directed or exercised actual control over the specific conduct that caused the injury.

Appellate courts in Florida have more recently examined the nondelegable duty issue, with differing opinions. As a result, the law is unsettled across the state regarding the liability of hospitals for the negligent acts or omissions of medical providers with whom they contract to provide medical services within the hospital, but over whom they do not have direct control of the manner in which the services are provided.

In *Wax v. Tenet Health System Hospitals, Inc.*, 955 So.2d 1 (Fla. 4th DCA 2006)[86], the wife of a deceased patient brought a medical malpractice action against the surgeon who operated on her husband, the hospital where the surgery was completed and others. The husband underwent elective hernia surgery, during which he suffered respiratory failure and died. The wife's wrongful death claim alleged negligence in the pre-surgical assessment, in the administration and management of anesthesia during surgery, and in the failed attempts to resuscitate the husband after he stopped

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[81] *Roessler v. Novak*, 858 So. 2d 1158, 1164-1165 (Fla. 2d DCA 2003)(Altenbernd, C.J., concurring).
[82] *See Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 852 (Fla. 2003).
[83] *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 853 (Fla. 2003).
[84] *See Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 855-856 (Fla. 2003).
[85] Chapter 624, F.S., provides for licensing of health insurers under the Florida Insurance Code. Chapter 636, F.S., provides for licensing of prepaid limited health service organizations and discount medical plan organizations. Chapter 641, F.S., provides for licensing of health maintenance organizations and prepaid health clinics.
[86] The case was originally heard in 2006. Following the filing of a Motion for Rehearing and a Motion for Rehearing En Banc by appellees, both of which were denied, the Court realized that it failed to resolve all issues and delivered an opinion regarding the hospital's liability for the alleged negligence of the anesthesiologist. The opinion was issued on May 7, 2007. *See* Wax, 955 So.2d at 6.

breathing.[87] Specifically, for purposes of this analysis, the wife alleged that the hospital had a nondelegable duty to provide anesthesiology services and was directly liable for the negligence of the anesthesiologist with whom the hospital had contracted to provide services.[88]

The *Wax* court agreed with the plaintiff that the statutory definition of "hospital"[89] and a specific regulation of hospitals established under statutory authority by the Agency for Health Care Administration (AHCA)[90] established that the hospital had an express legal duty to furnish anesthesia services to patients that were "consistent with established standards."[91] The court found that the imposition of this duty on all surgical hospitals to provide non-negligent anesthesia services was important enough to be nondelegable without the express consent to the contrary of the patient.[92] The hospital was found liable for the negligence of the anesthesiologist that caused the death of Wax under the theory of nondelegable duty.

In *Tarpon Springs Hospital Foundation, Inc. v. Reth,* 40 So.3d 823 (Fla. 2nd DCA 2010), the personal representative of a deceased patient filed a medical negligence claim against the anesthesiologist, nurse anesthetists, the anesthesia practice, and the hospital, alleging that negligent anesthesia services were provided to the patient, causing his death.[93] The hospital and other defendants appealed the trial court's order granting the plaintiff's amended motion for new trial and the denial of the hospital's motion for directed verdict.[94] The 2nd District Court of Appeal considered the same argument of the plaintiff related to the identical statutes and rules as were presented to the 4th District Court of Appeal in *Wax*. However, the court in *Reth* concluded that, while the hospital had a statutory obligation to maintain an anesthesia department within the hospital that is directed by a physician member of the hospital's professional staff, the statutes and rules do not impose a nondelegable duty to provide non-negligent anesthesia services to surgical patients of the hospital.[95] The court reversed the denial of the hospital's motion for directed verdict and remanded this case to the trial court with instructions that it enter a judgment in favor of the hospital.[96]

Noting the conflict among the District Courts of Appeal regarding the applicability of the theory of nondelegable duty to the contractual relationship between hospital and medical provider in medical negligence claims, the Second District certified the conflict to the Florida Supreme Court for further review.[97] However, as of the date of this analysis, the Florida Supreme Court has not resolved the conflict.

Effect of the Bill

The bill amends s. 768.0981, F.S. to provide that a hospital is not liable for the medical negligence of a health care provider with whom the hospital has entered into a contract, other than an employee of the hospital, unless the hospital expressly directs or exercises actual control over the specific conduct that caused injury. This bill would limit the inquiry as to whether the hospital "expressly" directed or exercised actual control over the conduct that caused the injury.

B. SECTION DIRECTORY:

Section 1: Creates s. 458.3175, F.S., relating to expert witness certificates.

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[87] *See* Wax v. Tenet Health System Hospitals, Inc., 955 So.2d 1, 3 (Fla. 4th DCA 2006).
[88] *See id.* at 6.
[89] S. 395.002(13)(b), F.S. (2005) defines "hospital" as an establishment that, among other things, regularly makes available "treatment facilities for surgery."
[90] Rule 59A-3.2085(4), F.A.C. states "[e]ach Class I and Class II hospital, and each Class III hospital providing surgical or obstetrical services, shall have an anesthesia department, service or similarly titled unit directed by a physician member of the organized professional staff."
[91] *See* Wax, 955 So.2d at 8.
[92] *See id.* at 9.
[93] *See* Reth, 40 So.3d at 823.
[94] *See id.* at 824.
[95] *See id.*
[96] *See id.*
[97] *See* Tarpon Springs Hospital Foundation, Inc. v. Reth, 40 So.3d 823, 824 (Fla. 2nd DCA 2010).

Section 2: Amends s. 458.331, F.S., relating to grounds for disciplinary action and action by the board and department.

Section 3: Amends s. 458.351, F.S., relating to reports of adverse incidents in office practice settings.

Section 4: Creates s. 459.0066, F.S., relating to expert witness certificates.

Section 5: Amends s. 459.015, F.S., relating to grounds for disciplinary action and action by the board and department.

Section 6: Amends s. 459.026, F.S., relating to reports of adverse incidents in office practice settings.

Section 7: Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts.

Section 8: Amends s. 766.102, F.S., relating to medical negligence, standards of recovery, and expert witnesses.

Section 9: Amends s. 766.106, F.S., relating to notice before filing action for medical negligence, presuit screening period, offers for admission of liability and for arbitration, and informal discovery.

Section 10: Creates s. 766.1065, F.S., relating to authorization for release of protected health information.

Section 11: Amends s. 766.206, F.S., relating to presuit investigation of medical negligence claims and defenses by a court.

Section 12: Amends s. 768.0981, F.S., relating to limitations on actions against insurers, prepaid limited health service organizations, health maintenance organizations, hospitals, or prepaid health clinics.

Section 13: Creates s. 466.005, F.S., relating to expert witness certificates.

Section 14: Amends s. 466.028, F.S., relating to grounds for disciplinary action and action by the board.

Section 15: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill requires physicians and dentists licensed in another state or Canada to pay a fee of not more than $50 to obtain an expert witness certificate in order to provide an expert witness opinion or provide expert testimony relating to the standard of care in a medical malpractice case involving a physician or dentist. The department estimates that during the first year there will be approximately 2,478 expert witness certificates applied for, thereby resulting in revenues of $123,900 to be deposited within the Medical Quality Assurance Trust Fund.

2. Expenditures:

   The Department of Health will require additional budget authority in contracted services for application processing and one OPS position to implement the provisions of the bill. The estimated cost will be less than $58,000 and will be absorbed within existing department resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill requires physicians and dentists licensed in another state or Canada to pay a fee of not more than $50 to obtain an expert witness certificate in order to provide an expert witness opinion or provide expert testimony relating to the standard of care in a medical malpractice case involving a physician or dentist.

D. FISCAL COMMENTS:

The fiscal impact on private parties is speculative.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

Access to Courts

Section 8 of the bill contains a provision that increases the standard of proof in certain medical negligence actions from preponderance of the evidence to clear and convincing evidence. Section 12 of the bill provides that a hospital is not liable, with some exceptions, for the medical negligence of a health care provider with whom the hospital has entered into a contract. Article 1, s. 21, Fla. Const., provides that the "courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." In *Kluger v. White*, 281 So. 2d 1, 4 (Fla. 1983), the Florida Supreme Court explained the constitutional limitation on the ability of the Legislature to abolish a civil cause of action:

> We hold, therefore, that where a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State pursuant to Fla. Stat. s. 2.01, F.S.A., the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.

In *Eller v. Shova*, 630 So. 2d 537, 540 (Fla. 1993), the court applied *Kluger* to a case that changed the standard of proof from simple negligence to gross negligence in some workers compensation actions:

> In analyzing [the standard quoted above] in *Kluger*, we stated that a statute that merely changed the degree of negligence necessary to maintain a tort action did not abolish a right to redress for an injury.

Justice Kogan warned that the ability to change the standard of proof is not unlimited:

> [F]ew would question that access to the courts is being denied if the legislature purports to preserve a cause of action but then insulates defendants with conclusive, irrebuttable presumptions. Such a "cause of action" would be little more than a legal sham used to circumvent article 1, section 21.[98]

Rules of Practice and Procedure in the Courts

Sections 1, 3, 4, 6, and 8 of the bill change provisions relating to expert witnesses and the admissibility of evidence during a civil trial. Article V, s. 2(a), Fla. Const., provides that the Florida Supreme Court "shall adopt rules for the practice and procedure" in all courts. The Florida Supreme Court has interpreted this provision to mean that the court has the exclusive power to create rules of practice and procedure. Sections 1 and 4 provide requirements for expert witnesses who do not possess a Florida license. Section 3 and 6 provide for admissibility of informed consent forms. Section 8 provides for exclusion of certain evidence even if the evidence is otherwise relevant. If a court were to find that any of these requirements encroached on the court's rulemaking power, it could hold the provisions invalid.

Sections 3, 6, and 8 specifically provide that certain documents are admissible in evidence. The Florida Supreme Court has held that some portions of the Evidence Code are substantive and can be set by the Legislature and some portions are procedural and can only be set by the rules of court. If a court were to find that the provisions in this bill related to admission of evidence are procedural, it could hold the provisions invalid pursuant to art. V, s. 2, Fla. Const.

B. RULE-MAKING AUTHORITY:

This bill requires that the Boards of Medicine and Osteopathic Medicine adopt rules establishing a standard informed consent form setting forth recognized specific risks relating to cataract surgery. The boards must consider information from physicians and osteopathic physicians regarding specific recognized risks of cataract surgery and must consider informed consent forms used in other states.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

The Civil Justice Subcommittee considered the bill on March 8, 2011, and adopted six amendments. The amendments:

- List the specific information that must be provided to the Department of Health in order for an out-of-state physician to receive an expert witness certificate and remove the requirement that boards make rules to implement the expert witness certificate program;
- Provide that the Department of Health will have the duty of issuing the expert witness certificates and give the Department 7 business days rather than 5 business days to issue the certificates;
- Provide that the Board of Medicine and the Board of Osteopathic Medicine will have the authority to discipline holders of expert witness certificates;
- Provide that the provision of the bill relating that limits the admission of evidence relating to insurer reimbursement policies and practices only applies in medical negligence actions;
- Provide that a prospective defendant may interview a claimant's health care providers if the health care providers agree to be interviewed;

[98] *Eller v. Shova*, 630 So. 2d 537, 543 (Fla. 1993)(Kogan, J., concurring in result only).

- Remove the provisions of the bill that exempt the rule requiring the creation of a new informed consent form for cataract surgery from possible legislative review; and
- Remove the requirement that the trial judge include a rebuttable presumption in the jury instructions.

This bill, as amended, was reported favorably as a committee substitute.

On March 23, 2011, the Health and Human Services Access Subcommittee adopted a strike-all amendment and an amendment to the strike-all amendment. The strike-all amendment:

- Requires an expert witness testifying for or against a dentist to be a licensed dentist under ch. 466, F.S., or possess an expert witness certificate issued under s. 466.005, F.S.
- Subjects a dentist licensed under chapter 466, F.S., to denial of a license or disciplinary action under s. 466.028(1)(ll) related to the submission of a verified written expert medical opinion.
- Creates s. 466.005, F.S., requiring the Department of Health to issue an expert witness certificate to a dentist licensed out-of-state or in Canada upon the satisfaction of requirements established by statute and payment of an application fee of $50.
- Makes an expert witness certificate issued under s. 466.005, F.S., valid for 2 years from the date of issuance.
- Allows the holder of an expert witness certificate issued under s. 466.005, F.S., to provide a verified written medical expert opinion as provided in s. 766.203, F.S., and provide expert testimony in pending medical negligence actions against a dentist regarding the prevailing standard of care.
- Clarifies that an expert witness certificate issued under s. 466.005, F.S., does not authorize a dentist to engage in the practice of dentistry and does not require a dentist, not otherwise licensed to practice dentistry in Florida, to obtain a license to practice dentistry or to pay license fees.
- Requires an expert witness certificate to be considered a license for purpose of disciplinary action and subjects the holder of the certificate to discipline to the Board of Dentistry.
- Renders as ground for denial of a license or disciplinary action the provision of misleading, deceptive, or fraudulent expert witness testimony related to the practice of dentistry.

The amendment to the strike-all amendment changed the number of years of professional time required to be devoted to active clinical practice, student instruction or clinical research on the part of an expert witness testifying against a health care provider from five to three years.

The bill was reported favorably as a Committee Substitute. The analysis reflects the Committee Substitute.

A bill to be entitled

An act relating to medical malpractice; creating ss. 458.3175, 459.0066, and 466.005, F.S.; requiring the Department of Health to issue expert witness certificates to certain physicians and dentists licensed outside of the state; providing application and certification requirements; establishing application fees; providing for the validity and use of certifications; exempting physicians and dentists issued certifications from certain licensure and fee requirements; amending ss. 458.331, 459.015, and 466.028, F.S.; providing additional acts that constitute grounds for denial of a license or disciplinary action to which penalties apply; providing construction with respect to the doctrine of incorporation by reference; amending ss. 458.351 and 459.026, F.S.; requiring the Board of Medicine and the Board of Osteopathic Medicine to adopt within a specified period certain patient forms specifying cataract surgery risks; specifying that an incident resulting from risks disclosed in the patient form is not an adverse incident; providing for the execution and admissibility of the patient forms in civil and administrative proceedings; creating a rebuttable presumption that a physician disclosed cataract surgery risks if the patient form is executed; amending s. 627.4147, F.S.; deleting a requirement that medical malpractice insurance contracts contain a clause authorizing the insurer to make and conclude certain offers within policy limits over the insured's veto;

amending s. 766.102, F.S.; defining terms; providing that certain insurance information is not admissible as evidence in medical negligence actions; establishing the burden of proof that a claimant must meet in certain damage claims against health care providers based on death or personal injury; requiring that certain expert witnesses who provide certain expert testimony meet certain licensure or certification requirements; excluding a health care provider's failure to comply with or breach of federal requirements from evidence in medical negligence cases in the state; amending s. 766.106, F.S.; requiring claimants for medical malpractice to execute an authorization form; allowing prospective medical malpractice defendants to interview a claimant's treating health care provider without notice to or the presence of the claimant or the claimant's legal representative; authorizing prospective defendants to take unsworn statements of a claimant's health care provider; creating s. 766.1065, F.S.; requiring that presuit notice for medical negligence claims be accompanied by an authorization for release of protected health information; providing requirements for the form of such authorization; amending s. 766.206, F.S.; requiring dismissal of a medical malpractice claim if such authorization is not completed in good faith; amending s. 768.0981, F.S.; limiting the liability of hospitals related to certain medical negligence claims; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 458.3175, Florida Statutes, is created to read:

458.3175 Expert witness certificate.—

(1)(a) The department shall issue a certificate authorizing a physician who holds an active and valid license to practice medicine in another state or a province of Canada to provide expert testimony in this state, if the physician submits to the department:

1. A complete registration application containing the physician's legal name, mailing address, telephone number, business locations, the names of the jurisdictions where the physician holds an active and valid license to practice medicine, and the license number or other identifying number issued to the physician by the jurisdiction's licensing entity; and

2. An application fee of $50.

(b) The department shall approve an application for an expert witness certificate within 7 business days after receipt of the completed application and payment of the application fee if the applicant holds an active and valid license to practice medicine in another state or a province of Canada and has not had a previous expert witness certificate revoked by the board. An application is approved by default if the department does not act upon the application within the required period. A physician must notify the department in writing of his or her intent to rely on a certificate approved by default.

(c) An expert witness certificate is valid for 2 years after the date of issuance.

(2) An expert witness certificate authorizes the physician to whom the certificate is issued to do only the following:

(a) Provide a verified written medical expert opinion as provided in s. 766.203.

(b) Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under this chapter or chapter 459.

(3) An expert witness certificate does not authorize a physician to engage in the practice of medicine as defined in s. 458.305. A physician issued a certificate under this section who does not otherwise practice medicine in this state is not required to obtain a license under this chapter or pay any license fees, including, but not limited to, a neurological injury compensation assessment. An expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.

Section 2. Subsection (11) is added to section 458.331, Florida Statutes, paragraphs (oo) through (qq) of subsection (1) of that section are redesignated as paragraphs (pp) through (rr), respectively, and a new paragraph (oo) is added to that subsection, to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a

license or disciplinary action, as specified in s. 456.072(2):

(oo) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 3. Subsection (6) of section 458.351, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section to read:

458.351 Reports of adverse incidents in office practice settings.—

(6)(a) The board shall adopt rules establishing a standard informed consent form that sets forth the recognized specific risks related to cataract surgery. The board must propose such rules within 90 days after the effective date of this subsection.

(b) Before formally proposing the rule, the board must consider information from physicians licensed under this chapter or chapter 459 regarding recognized specific risks related to cataract surgery and the standard informed consent forms adopted for use in the medical field by other states.

(c) A patient's informed consent is not executed until the patient, or a person authorized by the patient to give consent, and a competent witness sign the form adopted by the board.

(d) An incident resulting from recognized specific risks described in the signed consent form is not considered an

adverse incident for purposes of s. 395.0197 and this section.

(e) In a civil action or administrative proceeding against a physician based on his or her alleged failure to properly disclose the risks of cataract surgery, a patient's informed consent executed as provided in paragraph (c) on the form adopted by the board is admissible as evidence and creates a rebuttable presumption that the physician properly disclosed the risks.

Section 4. Section 459.0066, Florida Statutes, is created to read:

459.0066 Expert witness certificate.—

(1)(a) The department shall issue a certificate authorizing a physician who holds an active and valid license to practice osteopathic medicine in another state or a province of Canada to provide expert testimony in this state, if the physician submits to the department:

1. A complete registration application containing the physician's legal name, mailing address, telephone number, business locations, the names of the jurisdictions where the physician holds an active and valid license to practice osteopathic medicine, and the license number or other identifying number issued to the physician by the jurisdiction's licensing entity; and

2. An application fee of $50.

(b) The department shall approve an application for an expert witness certificate within 7 business days after receipt of the completed application and payment of the application fee if the applicant holds an active and valid license to practice

osteopathic medicine in another state or a province of Canada and has not had a previous expert witness certificate revoked by the board. An application is approved by default if the department does not act upon the application within the required period. A physician must notify the department in writing of his or her intent to rely on a certificate approved by default.

(c) An expert witness certificate is valid for 2 years after the date of issuance.

(2) An expert witness certificate authorizes the physician to whom the certificate is issued to do only the following:

(a) Provide a verified written medical expert opinion as provided in s. 766.203.

(b) Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under chapter 458 or this chapter.

(3) An expert witness certificate does not authorize a physician to engage in the practice of osteopathic medicine as defined in s. 459.003. A physician issued a certificate under this section who does not otherwise practice osteopathic medicine in this state is not required to obtain a license under this chapter or pay any license fees, including, but not limited to, a neurological injury compensation assessment. An expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.

Section 5. Subsection (11) is added to section 459.015, Florida Statutes, paragraphs (qq) through (ss) of subsection (1)

of that section are redesignated as paragraphs (rr) through (tt), respectively, and a new paragraph (qq) is added to that subsection, to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(qq) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of osteopathic medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 6. Section 466.005, Florida Statutes, is created to read:

466.005 Expert witness certificate.—

(1)(a) The department shall issue a certificate authorizing a dentist who holds an active and valid license to practice dentistry in another state or a province of Canada to provide expert testimony in this state, if the dentist submits to the department:

1. A complete registration application containing the dentist's legal name, mailing address, telephone number, business locations, the names of the jurisdictions where the dentist holds an active and valid license to practice dentistry, and the license number or other identifying number issued to the

dentist by the jurisdiction's licensing entity; and

2. An application fee of $50.

(b) The department shall approve an application for an expert witness certificate within 7 business days after receipt of the completed application and payment of the application fee if the applicant holds an active and valid license to practice dentistry in another state or a province of Canada and has not had a previous expert witness certificate revoked by the board. An application is approved by default if the department does not act upon the application within the required period. A dentist must notify the department in writing of his or her intent to rely on a certificate approved by default.

(c) An expert witness certificate is valid for 2 years after the date of issuance.

(2) An expert witness certificate authorizes the dentist to whom the certificate is issued to do only the following:

(a) Provide a verified written medical expert opinion as provided in s. 766.203.

(b) Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a dentist licensed under this chapter.

(3) An expert witness certificate does not authorize a dentist to engage in the practice of dentistry as defined in s. 466.003. A dentist issued a certificate under this section who does not otherwise practice dentistry in this state is not required to obtain a license under this chapter or pay any license fees. An expert witness certificate shall be treated as

a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.

Section 7. Subsection (8) is added to section 466.028, Florida Statutes, paragraph (ll) of subsection (1) of that section is redesignated as paragraph (mm), and a new paragraph (ll) is added to that subsection, to read:

466.028 Grounds for disciplinary action; action by the board.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(ll) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of dentistry.

(8) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 8. Subsection (6) of section 459.026, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section to read:

459.026 Reports of adverse incidents in office practice settings.—

(6)(a) The board shall adopt rules establishing a standard informed consent form that sets forth the recognized specific risks related to cataract surgery. The board must propose such rules within 90 days after the effective date of this subsection.

(b) Before formally proposing the rule, the board must consider information from physicians licensed under chapter 458 or this chapter regarding recognized specific risks related to cataract surgery and the standard informed consent forms adopted for use in the medical field by other states.

(c) A patient's informed consent is not executed until the patient, or a person authorized by the patient to give consent, and a competent witness sign the form adopted by the board.

(d) An incident resulting from recognized specific risks described in the signed consent form is not considered an adverse incident for purposes of s. 395.0197 and this section.

(e) In a civil action or administrative proceeding against a physician based on his or her alleged failure to properly disclose the risks of cataract surgery, a patient's informed consent executed as provided in paragraph (c) on the form adopted by the board is admissible as evidence and creates a rebuttable presumption that the physician properly disclosed the risks.

Section 9. Paragraph (b) of subsection (1) of section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.—

(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or s. 624.462 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:

(b)1. ~~Except as provided in subparagraph 2., a clause~~

~~authorizing the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.~~

~~2.a. With respect to dentists licensed under chapter 466,~~ A clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.

2.~~b.~~ If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission

of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

Section 10. Subsections (3), (4), and (5) of section 766.102, Florida Statutes, are amended, subsection (12) of that section is renumbered as subsection (14), and new subsections (12) and (13) are added to that section, to read:

766.102 Medical negligence; standards of recovery; expert witness.—

(3)(a) As used in this subsection, the term:

1. "Insurer" means any public or private insurer, including the Centers for Medicare and Medicaid Services.

2. "Reimbursement determination" means an insurer's determination of the amount that the insurer will reimburse a health care provider for health care services.

3. "Reimbursement policies" means an insurer's policies and procedures governing its decisions regarding health insurance coverage and method of payment and the data upon which such policies and procedures are based, including, but not

limited to, data from national research groups and other patient safety data as defined in s. 766.1016.

(b) The existence of a medical injury does ~~shall~~ not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider. Any records, policies, or testimony of an insurer's reimbursement policies or reimbursement determination regarding the care provided to the plaintiff are not admissible as evidence in any medical negligence action. However, the discovery of the presence of a foreign body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

(4)(a) The Legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers. The failure of a health care provider to order, perform, or administer supplemental diagnostic tests is ~~shall~~ not ~~be~~ actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care.

(b) In an action for damages based on death or personal injury which alleges that such death or injury resulted from the failure of a health care provider to order, perform, or

administer supplemental diagnostic tests, the claimant has the burden of proving by clear and convincing evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care.

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless the ~~that~~ person is a ~~licensed~~ health care provider who holds an active and valid license and conducts a complete review of the pertinent medical records and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research

program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice or consultation as a general practitioner;

2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;

2. The instruction of students in an accredited health

professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

(12) If a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 is the party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must be licensed under chapter 458, chapter 459, or chapter 466 or possess a valid expert witness certificate issued under s. 458.3175, s. 459.0066, or s. 466.005.

(13) A health care provider's failure to comply with or breach of any federal requirement is not admissible as evidence in any medical negligence case in this state.

Section 11. Paragraph (a) of subsection (2), subsection (5), and paragraph (b) of subsection (6) of section 766.106, Florida Statutes, are amended to read:

766.106 Notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.—

(2) PRESUIT NOTICE.—

(a) After completion of presuit investigation pursuant to s. 766.203(2) and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant

by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, ~~and~~ copies of all of the medical records relied upon by the expert in signing the affidavit, and the executed authorization form provided in s. 766.1065. ~~The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.~~

(5) DISCOVERY AND ADMISSIBILITY.—A ~~No~~ statement, discussion, written document, report, or other work product generated by the presuit screening process is not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process. This subsection does not prevent a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 who submits a verified written expert medical opinion from being subject to denial of a license or disciplinary action under s. 458.331(1)(oo), s. 459.015(1)(qq), or s. 466.028(1)(ll).

(6) INFORMAL DISCOVERY.—

(b) Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations, as follows:

1. Unsworn statements.—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

2. Documents or things.—Any party may request discovery of documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce discoverable documents or things within that party's possession or control. Medical records shall be produced as provided in s. 766.204.

3. Physical and mental examinations.—A prospective defendant may require an injured claimant to appear for examination by an appropriate health care provider. The

prospective defendant shall give reasonable notice in writing to all parties as to the time and place for examination. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination must be determined by the nature of the claimant's condition, as it relates to the liability of each prospective defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

4. Written questions.—Any party may request answers to written questions, the number of which may not exceed 30, including subparts. A response must be made within 20 days after receipt of the questions.

5. Ex parte interviews of treating health care providers.—A prospective defendant or his or her legal representative may interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative.

6.~~5.~~ Unsworn statements of treating health care providers ~~Medical information release. The claimant must execute a medical information release that allows~~ A prospective defendant or his or her legal representative may also ~~to~~ take unsworn statements of the claimant's treating health care providers ~~physicians~~. The statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death.

Subject to the procedural requirements of subparagraph 1., a prospective defendant may take unsworn statements from a claimant's treating physicians. Reasonable notice and opportunity to be heard must be given to the claimant or the claimant's legal representative before taking unsworn statements. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.

Section 12. Section 766.1065, Florida Statutes, is created to read:

766.1065 Authorization for release of protected health information.—

(1) Presuit notice of intent to initiate litigation for medical negligence under s. 766.106(2) must be accompanied by an authorization for release of protected health information in the form specified by this section, authorizing the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2).

(2) If the authorization required by this section is revoked, the presuit notice under s. 766.106(2) is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

(3) The authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" in 45 C.F.R. parts 160 and 164:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, (...Name of patient or authorized representative...) [hereinafter "Patient"], authorize that (...Name of health care provider to whom the presuit notice is directed...) and his/her/its insurer(s), self-insurer(s), and attorney(s) may obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. Facilitating the investigation and evaluation of the medical negligence claim described in the accompanying presuit notice; or

2. Defending against any litigation arising out of the medical negligence claim made on the basis of the accompanying presuit notice.

B. The health information obtained, used, or disclosed extends to, and includes, the verbal as well as the written and is described as follows:

1. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient in connection with injuries complained of after the alleged act of negligence: (List the name and current address of all health care providers). This authorization extends to any additional health care providers that may in the future

evaluate, examine, or treat the Patient for the injuries complained of.

2. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient during a period commencing 2 years before the incident that is the basis of the accompanying presuit notice.

(List the name and current address of such health care providers, if applicable.)

C. This authorization does not apply to the following list of health care providers possessing health care information about the Patient because the Patient certifies that such health care information is not potentially relevant to the claim of personal injury or wrongful death that is the basis of the accompanying presuit notice.

(List the name of each health care provider to whom this authorization does not apply and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure. If none, specify "none.")

D. The persons or class of persons to whom the Patient authorizes such health information to be disclosed or by whom such health information is to be used:

1. Any health care provider providing care or treatment for the Patient.

2. Any liability insurer or self-insurer providing liability insurance coverage, self-insurance, or defense to any health care provider to whom presuit notice is given regarding the care and treatment of the Patient.

3. Any consulting or testifying expert employed by or on behalf of (name of health care provider to whom presuit notice was given), his/her/its insurer(s), self-insurer(s), or attorney(s) regarding to the matter of the presuit notice accompanying this authorization.

4. Any attorney (including secretarial, clerical, or paralegal staff) employed by or on behalf of (name of health care provider to whom presuit notice was given) regarding the matter of the presuit notice accompanying this authorization.

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of the Patient.

E. This authorization expires upon resolution of the claim or at the conclusion of any litigation instituted in connection with the matter of the presuit notice accompanying this authorization, whichever occurs first.

F. The Patient understands that, without exception, the Patient has the right to revoke this authorization in writing. The Patient further understands that the consequence of any such revocation is that the presuit notice under s. 766.106(2), Florida Statutes, is deemed

retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

G. The Patient understands that signing this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. The Patient understands that information used or disclosed under this authorization may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative: ....

Date: ....

Name of Patient/Representative: ....

Description of Representative's Authority: ....

Section 13. Subsection (2) of section 766.206, Florida Statutes, is amended to read:

766.206 Presuit investigation of medical negligence claims and defenses by court.—

(2) If the court finds that the notice of intent to initiate litigation mailed by the claimant does ~~is~~ not comply ~~in compliance~~ with the reasonable investigation requirements of ss. 766.201-766.212, including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202, or that the authorization accompanying the notice of intent required under s. 766.1065 is not completed in good

faith by the claimant, the court shall dismiss the claim, and the person who mailed such notice of intent, whether the claimant or the claimant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 14. Section 768.0981, Florida Statutes, is amended to read:

768.0981 Limitation on actions against insurers, prepaid limited health service organizations, health maintenance organizations, hospitals, or prepaid health clinics.—An entity licensed or certified under chapter 395, chapter 624, chapter 636, or chapter 641 is ~~shall~~ not ~~be~~ liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

Section 15. This act shall take effect July 1, 2011.