IN THE FIFTH DISTRICT
COURT OF APPEALS

CASE NO. 05-1735

ADVENTIST HEALTH SYSTEM/SUNBELT, INC.
A/K/A FLORIDA HOSPITAL,

Appellant,

vs.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.,
HEALTH OPTIONS, INC.,

Appellees.

On Appeal From The Circuit Court Of The Ninth Judicial Circuit
In And For Orange County, Florida

BRIEF OF *AMICI CURIAE* FLORIDA HOSPITAL ASSOCIATION, FLORIDA COLLEGE OF EMERGENCY PHYSICIANS, FLORIDA MEDICAL ASSOCIATION, and the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER AUTHORITIES

RULES

RECORD

STATEMENT OF IDENTITY AND INTEREST OF *AMICI*

The Florida Hospital Association (the "FHA") is a not-for-profit association representing all types of hospitals throughout the state. Through advocacy, education, research, representation, and service, the FHA carries out its mission "to promote the ability of member hospitals and healthcare systems to effectively and efficiently serve the healthcare needs of their communities." Currently, FHA's membership includes over 200 hospitals, 20 professional membership groups and councils, and over 1,800 professional members.

The Florida College of Emergency Physicians ("FCEP") is a state chapter of the American College of Emergency Physicians and represents more than 1,100 emergency physicians in the State of Florida. FCEP member physicians represent the health care safety net of Florida's residents and visitors. More than seven million patients seek care annually in Florida emergency departments. FCEP was founded on October 15, 1971, and is headquartered in Orlando.

The Florida Medical Association (the "FMA") is a not-for-profit corporation which is organized and maintained for the benefit of the approximately 16,000 licensed Florida physicians who comprise its membership. The FMA was created and exists for the purpose of securing and maintaining the highest standards of practice in medicine and to further the interests of its members. One of the primary purposes of the FMA is to act on behalf of its members by representing their

common interests before the courts of the State of Florida. Members of the FMA are substantially affected by state or national statutes, rules, regulations, and policies applicable to health care claims.

The American College of Emergency Physicians ("ACEP") is a nonprofit, voluntary professional and educational society of nearly 23,000 emergency physicians practicing in the United States and other countries. Founded in 1968, ACEP is the nation's oldest and largest association of emergency physicians. ACEP fosters the highest quality of emergency medical care through the education of emergency physicians, other health care professionals, and the public; the promotion of research; the development and promotion of public health and safety initiatives; and the provision of leadership in the development of health care policy.

The primary legal issue raised in this case (namely the enforceability of Florida's Emergency Services Statute by health care providers) is of significant importance to the instant *amici* and their members since the Emergency Services Statute, § 641.513, is the primary means by which the Florida Legislature sought to guarantee that health care providers were compensated promptly and fully for having to render emergency care and services to HMO subscribers. The hospitals represented by the FHA and the physicians represented by the FCEP, the FMA, and ACEP are required, by law, to provide emergency care to HMO subscribers

and to submit those claims to HMOs for reimbursement. Moreover, the appropriate level of reimbursement under the Emergency Services Statute has long been a contentious issue between HMOs and medical providers that now needs resolution. Hence, the instant *amici* and their members have an important stake in the outcome of this case and also have significant expertise and knowledge on the issues raised by this appeal.

SUMMARY OF ARGUMENT

The trial court below granted Blue Cross' motion for judgment on the pleadings (and declined to enter its previous award of summary judgment to Florida Hospital) because it found that Florida Statute § 641.513 did not contain a private right of action and that any declaration of the reimbursement rates mandated thereunder would be an impermissible advisory opinion. The Circuit Court's decision should be reversed. The Florida Legislature clearly intended that medical providers be able to enforce the "Emergency Services" statute (the "Statute"). The clearest proof is the very text of § 641.513 itself. Under the explicit mandates of that Statute, a provider ***has*** to render certain emergency services to HMO subscribers who seek their help. In return, HMOs are required, in the absence of a negotiated agreement discounting the provider's charges, to pay the medical provider its usual and customary charges for the emergency services rendered. The Statute is very explicit in both requiring payment and in setting the

parameters for reimbursement. To preclude providers from enforcing the Emergency Services Statute would not only be contrary to the text of the statute and the legislative intent behind it, but would completely eviscerate it. Without a private right of action under that Statute: 1) § 641.513 would require that claims for emergency services "shall be paid," but would not empower providers to actually collect those claims from HMOs who do not pay emergency claims; 2) the same statute would even set the reimbursement level for those claims, but would not allow providers to collect those monies or to seek redress for any underpayments made by the HMOs for emergency services rendered; and, 3) although the terms of the Statute are specifically mandatory, providers would not be able to invoke its protections. Clearly, the Florida Legislature did not intend § 641.513 to be unenforceable by health care providers.

In addition, it is clear that providers may seek an interpretation of the reimbursement levels required to be paid by HMOS under § 641.513 through a declaratory judgment claim regardless. Florida's Declaratory Judgment Act specifically allows actions to be brought to interpret a statute. Moreover, it is clear that there is a very real dispute between the parties here (and between providers and HMOs in general) over the reimbursement rates mandated by § 641.513 that now requires judicial interpretation since Florida's Agency for Health Care

Administration ("AHCA") has specifically left this very issue to be resolved by the courts.

ARGUMENT

I. Providers Can Sue HMOs Under the Emergency Services Statute.

A. The Statute

The issue of whether medical providers can sue HMOs for failing to fully and timely pay claims for emergency medical services rendered to their subscribers is answered clearly and unequivocally in both the federal and Florida Statutes. The Emergency Medical Transfer and Act of Labor Act ("EMTALA")(42 U.S.C. § 1395dd) and Florida Statute § 395.1041 (entitled "Access to emergency services and care") generally require that hospital emergency departments and emergency room physicians provide necessary medical care, screening, and treatment to stabilize a potential emergency medical condition prior to requesting any insurance or HMO information from a presenting patient. Florida Statute § 641.513 sets out the appropriate reimbursement procedures and level for such emergency health care treatment when the provider does not have a contract with the HMO to which the patient belongs.

When a doctor or hospital provides services to an HMO member, the statute generally prohibits the medical provider from collecting payment from the insured—other than a specified co-payment — for the emergency services

rendered. See Fla. Stats. §§ 641.3154(4) and 641.513(4). The HMO, in turn, is obligated to pay the provider's claim regardless of whether the provider has a contract with the HMO to pay a previously-negotiated rate. See Fla. Stats. §§ 641.3154(1), 641.3155(3)(e) and 641.513(5). More specifically, Florida Statute § 641.513 states unequivocally that:

> Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:
>
> (a) The provider's charges;
> (b) The usual and customary provider charges for similar services in the same community where the services were provided; or
> (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.
>
> Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

Despite the explicit text of the Statute calling for the payment of "charges," Florida HMOs (including Blue Cross here) have unilaterally set their reimbursement rates for emergency claims at 120 percent (or so) of Medicare rates (even though the Statute does not tie reimbursement levels to Medicare rates and attempts to tie reimbursement rates to a percentage of Medicare have been repeatedly rebuffed by the Florida Legislature in recent years). [1]

[1] See, *e.g.*, Senate Bill 2350 (2004)(draft of bill would have limited hospital reimbursement for emergency services to 120 percent of the Medicare rate, but bill was not even voted on during the legislative session).

B. Legislative Intent

As the Florida Supreme Court has noted, "[i]t must be assumed that a provision enacted by the legislature is intended to have some useful purpose." Smith v. Piezo Technology and Professional Adm'rs, 427 So.2d 182, 184 (Fla. 1983). This means that

> [w]here a statute requires an act to be done for the benefit of another or forbids the doing of an act which may be to his injury, though no action be given in express terms by the statute for the omission or commission, the general rule of law is that the party injured should have an action; for where a statute gives a right, there, although in express terms it has not given a remedy, the remedy by law which is properly applicable to that right follows as an incident.

Girard Trust Co. v. Tampashores Development Co., 117 So. 786, 788 (1928). See also Moyant v. Beattie, 561 So.2d 1319 (Fla. 4th DCA 1990)(quoting 49 Fla. Jur.2d, Statutes § 223 (1984)("If a statute grants a right or imposes a duty, it may be construed as conferring by implication the power necessary for the exercise of the right or the performance of the duty.") "In general, a statute that does not purport to establish civil liability but merely makes provision to secure the safety or welfare of the public as an entity, will not be construed as establishing a civil liability." Murthy v. N. Sinha Corp., 644 So. 2d 983, 986 (Fla. 1994). Here, it must be clear that the Statute was not enacted merely to secure the safety or welfare of the public as an entity. Rather, § 641.513 was clearly enacted to require HMOs to pay for emergency services and care and to require HMOs to pay for

those services at the amounts set forth in § 641.513(5). In exchange for requiring healthcare providers (who are not generally able to bill the patient) to provide emergency care to HMO patients with whom the health care provider has not contracted, the legislature required HMOs to pay the statutorily required amount. The terms of the Statute regulate only the conduct of health care providers and HMOs, and not the public in general. If health care providers have no private right of action to enforce the HMOs' payment obligation under § 641.513, they would truly be without a legal remedy to recover full payment for emergency medical services they were obligated to perform by law. This is clearly not what the Florida Legislature intended in passing a Statute that specifically mandates HMO payments to providers for emergency services and specifically mandates an enumerated payment formula.

C. Legislative History

By this statutory scheme, the Florida Legislature intended "that subscribers will receive needed services for which hospitals and emergency room physicians ***will*** receive reimbursement." See S.B. 886 (May 4, 1996), Final Bill and Economic Impact Statement at p. 4 (emphasis supplied). Indeed, the legislative history confirms that providers have every right to seek payment from HMOs for emergency services and care rendered to their subscribers. According to one pertinent Senate Staff Analysis referencing § 641.513:

> Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral… The HMO ***must*** compensate the provider for screening, evaluation, and examination reasonably calculated… [and] the HMO ***must also*** compensate the provider for emergency services and care.

See Fla. S. Comm. on Fiscal Policy, CS for SBs 1508, 706 & 2234 (2000) Staff Analysis at p. 4 (April 26, 2000)(emphasis supplied)(available online at http:/www.flsenate.gov/data/session/2000/Senate/bills/analysis/pdf/SB1508.fp.pdf) Thus, even these brief excerpts from the relevant legislative history confirm that § 641.513 was specifically intended to mandate HMO payments to health care providers for emergency services, screening, evaluation, examination, and care. The terms of the Statute are mandatory and it is clear that the legislature intended that such payments be obligatory. Hence, it can only follow that health care providers be allowed to collect such obligatory payments.

D. No Administrative Alternative

Moreover, Blue Cross' argument that the authority to enforce the Statute lies in the hands of Florida regulators is wrong. Neither the Florida Department of Insurance (n/k/a the Office of Insurance Regulation or the "OIR") nor AHCA have the power to pursue civil claims against HMOs requiring HMOs to reimburse providers when the HMOs fail to make proper payments under § 641.513. Indeed, AHCA has already acknowledged two things relevant to the interpretation of § 641.513 and this appeal. First, it determined that the HMOs' practice of paying

non-contracting providers 120% of the Medicare allowable rate "appears to be in violation of section 641.513(5), Florida Statutes" because the calculation is based on amounts "paid" and not, as required, the "usual and customary provider charges for similar services in the community where the services were provided." (R. 100, 196) under § 641.513. Second, AHCA also acknowledged that, in a letter dated November 4, 2003, it did not have the power to interpret § 641.513(5):

> During the past year the Agency, members of the HMO industry, various provider groups and their representatives have been having some very detailed discussions regarding certain payment practices by HMOs for the provision of emergency services. Section 641.513, Florida Statutes specifies the amount of payment a non-contracted provider must be paid when providing services to an HMO member in emergency situations.
>
> At issue specifically is section 641.513(5)(b), Florida Statutes that reads as follows:
>
> * * *
>
> The members of the HMO industry that have met with the Agency have established payment policies such that they pay percentages of the Medicare Allowable Charges for emergency services, which, they represent comply with section 641.513(5)(b), Florida Statutes. In these situations the HMOs are paying between 100% and 120% of Medicare allowable charges for emergency services rendered to commercial (non-Medicare and non-Medicaid) subscribers. The provider community involved with these discussions has taken exception to that practice.
>
> ***As the Agency does not have specific rule making authority to determine what specific payment amounts would comply with Section 641.513(5)(b), Florida Statutes,*** we suggest that a court of competent jurisdiction or the provider dispute resolution program as outlined in section 408.7057, Florida Statutes, is the appropriate venue for the parties to such disputes to settle this issue in those situations in which the parties involved cannot reach an agreement on their own.

(R. 101-02) (emphasis added)

Hence, the HMOs cannot point to any statutory mechanism whereby any governmental body can require HMOs to pay providers the amounts they have been underpaid or not paid under Florida Statute § 641.513**.** The possible imposition of penalties and fines payable to the government does not provide a monetary remedy to individual providers injured by violations of the Emergency Services Statute. Accordingly, the only way providers can recover damages for the HMOs' routine underpayment or non-payment of emergency services claims under § 641.513 is to bring civil actions against them.

E. Other Statutory Analogies

A statutory scheme analogous to the one at issue in this case is the statutory scheme relating to payment for personal injury protection ("PIP") benefits under automobile insurance policies. The issue in this case relates to emergency services and care. Almost all of the claims arising under PIP sections of automobile insurance policies are for emergency services and care. Florida Statute § 627.736 requires automobile insurance companies to pay for services provided in accordance with that Chapter. Until § 627.736 was amended in 2003, there was no specific private right of action for violating that statutory section. Notwithstanding the fact that there was no language in that statute specifically authorizing a private suit, numerous lawsuits have been litigated over insurance carriers' failures to

properly pay in accordance with the terms of § 627.736. See Allstate Ins. Co. v. Kaklamanos, 843 So. 2d 885 (Fla. 2003); Gurney v. State Farm Mut. Auto. Ins. Co., 795 So.2d 1118 (Fla. 5th DCA 2001); and Reg'l MRI of Orlando, Inc. v. Nationwide Mut. Fire Ins. Co., 884 So.2d 1102 (Fla. 5th DCA 2004).

Under this analogous statutory scheme, Florida courts have readily determined that there is a private right of action for violating § 627.736. The only difference between § 627.736 and § 641.513 is that § 641.513 is much more specific and narrowly focused as it applies only to emergency services and care and only between providers and HMOs. Despite the numerous contingencies and factors that exist under § 627.736, the only required determination under §641.513(5) is whether the HMOs paid the proper amounts thereunder. Clearly, if the Florida Supreme Court has allowed a private right of action under § 627.736, providers must also be able to similarly enforce § 641.513 for analogous kinds of health care claims.

Blue Cross has argued previously that the PIP Act is distinguishable, because there are two references to lawsuits in that statute. However, it should be noted that the HMO Act contains numerous references to lawsuits to enforce its terms, see ' 641.28 (expressly recognizing civil remedy); ' 641.282 (payment of judgment by HMO); ' 641.3154(4)(b) (acknowledging that court of competent jurisdiction can determine that organization is liable for payments to provider); '

641.3917 (recognizing rights under general, civil and common law, and that no action of the department Ashall abrogate such rights to damage or other relief in any court@). Additionally, the dispute resolution statutes relied upon by Blue Cross as providing the Aexclusive@ administrative remedy specifically state that they do not apply if the claim Ais the basis for an action pending in state or federal court,@ see ' 408.7056(2)(f) and ' 408.7057(2)(b)(6). Therefore, healthcare providers must be able to enforce the express terms of § 641.513 to obtain full reimbursement for any emergency services and care rendered to HMO subscribers.

II. The Florida Physicians Union And Villazon Cases Are Inapposite.

In granting Blue Cross' motion for judgement on the pleadings, the Circuit Court relied solely on the case of Florida Physicians Union, Inc. v. United Healthcare of Florida, Inc., 837 So.2d 1133 (Fla. 5th DCA 2002) in holding that an interpretation of the payment obligations set out in § 641.513 would lead it to render an impermissible advisory opinion. But, the Florida Physicians Union case is wholly inapposite. In that case, providers who had a contract with United Healthcare's HMO filed a lawsuit seeking a declaration that various payment methods used by the HMO to pay their contracted claims violated § 641.3903 of Florida's HMO Act. More specifically, the contracted providers claimed that United engaged in unfair claims settlement practices when it systematically downcoded their claims, thereby denying them full reimbursement thereon. This

Court found that § 641.3903 (which merely contains definitions for terms used throughout the HMO Act) did not provide a private right of action by contracted providers against HMOs.

In this case, however, Florida Hospital has not brought suit on some statute that merely defines terms under the HMO Act and it has no contract with Blue Cross. Rather, Florida Hospital has brought suit simply to declare the HMOs' payment obligations under a statute that mandates payments by HMOs to providers for the obligatory rendering of emergency services and care. Section 641.513 provides that "[t]he health maintenance organization ***shall*** compensate the provider for emergency services and care," and sets forth a specific formula at subsection (5) by which providers who do not have contracts with an HMO are to be paid for rendering those emergency medical services (emphasis supplied). Hence, the Statute clearly imposes an obligation upon HMOs to pay medical providers for emergency services rendered to the HMOs' subscribers. This is more than enough to provide a private right of action and to make the Florida Physicians Union case completely distinguishable from the legal issue raised in this appeal.

In the Court below, Blue Cross also relied upon Villazon v. Prudential Healthcare Plan, Inc., 843 So.2d 842 (Fla. 2003) for the argument that there is no private right of action under § 641.513. But, Villazon is also wholly distinguishable. Villazon involved a claim of negligence against an HMO

subscriber's healthcare providers and also against the subscriber's HMO. In this case, Florida Hospital has not asserted a claim for negligence or any other tort alleging that Blue Cross is liable for the actions of its providers. Moreover, and perhaps most importantly, Villazon found that a private right of action for damages did not exist under Florida's "Health Maintenance Organization Act" (the "HMO Act"). The HMO Act is specifically defined as Florida Statutes §§ 641.1-641.3923, and does no include § 641.513. Villazon does not apply to **provider** claims for emergency services, which do not arise under the HMO Act, but under Florida Statute § 641.513. Hence, the Villazon case is similarly irrelevant to this appeal.

III. The Courts Have Authority To Construe The Emergency Services Statute Pursuant to Florida's Declaratory Judgment Act.

Even if it were determined that Florida's Emergency Services Statute did not allow for a provider cause of action to sue for monies due thereunder, providers should still be able to sue for a declaratory judgment interpreting § 641.513 and the reimbursement formula set out therein. Florida Statute § 86.021, entitled "Power to Construe" explicitly provides that any person:

> whose rights, status, or other equitable or legal relations are affected by a statute, or any regulation made under statutory authority, or by municipal ordinance . . . ***may have determined any question of construction*** or validity arising under such statute, regulation, municipal ordinance . . . .

See § 86.021, Fla. Stat. (emphasis added).

Florida's Declaratory Judgment Act, thus, specifically provides Florida courts with the authority to interpret statutes and providers should—at the very least—be allowed to seek an interpretation of § 641.513(5)'s payment obligations to determine whether they are being properly and fully paid by HMOs thereunder. This is the whole point of the Emergency Services Statute.

The issue of whether a specific statute provides a private right of action is completely irrelevant to whether the courts have the power to interpret a statute pursuant to a declaratory judgment act. The test is whether there is an actual and present controversy between the parties that needs resolution. As a North Carolina appeals court recently noted, "[a]lthough it is not necessary that one party have an actual right of action against another to satisfy the jurisdictional requirement of an actual controversy, it is necessary that litigation appear unavoidable." National Travel Services, Inc. v. State ex rel. Cooper, 569 S.E.2d 667, 669 (N.C.App. 2002). In this case, the issue of the appropriate level of reimbursement has been a raging controversy in Florida's health care industry for several years (as evidenced by the AHCA correspondence quoted above) and it is an issue that demands resolution. Hence, at the very least, providers should be able to bring a declaratory judgment claim to determine how much HMOs have to pay them for rendering emergency care and services to their members under § 641.513.

IV. The Statute's Unambiguous Terms Provide That HMOs Must Pay Providers Their Reasonable and Customary Charges In the Absence of A Contract.

Section 641.513(5) sets out the specific rates by which HMOs must reimburse providers for rendering of emergency services and care to their members. That subsection provides that:

> Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:
>
> (a) The provider's charges;
>
> (b)The usual and customary provider charges for similar services in the same community where the services were provided; or
>
> (c)The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.[2]
>
> Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

The Circuit Court originally granted partial summary judgment to Florida Hospital on the grounds that the phrase "usual and customary provider charges" was unambiguous and meant "charges" and not, as Blue Cross contended, some unilaterally-determined percentage of Medicare reimbursement rates. This decision

[2] It is also important to note that Blue Cross' own subscriber handbook uses the same phrase and definition. Hence, Florida Hospital could have asked for an interpretation of that document as well. The interpretation of either must lead to the

of the Circuit Court should be reinstated as the reimbursement formula mandated by § 641.513(5) truly is unambiguous.

As the Florida Supreme Court has explained:

> when the language of a statute is clear and unambiguous and conveys a clear and definite meaning, there is no occasion to resorting to the rules of statutory construction; the statute must be given its plain and obvious meaning.

A.R. Douglass, Inc. v. McRainey, 102 Fla. 1141, 1144 (1931). Here, the Statute requires HMOs to pay providers their "usual and customary charges" or to pay them the "usual and customary provider charges for similar services in the same community where the services were provided Blue Cross' own Member Handbook uses the exact same terms and definitions in the exact same context. (R. 109-113) See also Florida Statute § 409.9128 (also containing the same "usual and customary provider charges" phrase). Moreover, the phrase "usual and customary charges" occurs at least ten different times in the Florida Statutes, and always in the context of billed "charges" (and never as some notion of discounted charges or fees, as suggested by Blue Cross). Lastly, the Florida Legislature has chosen to tie reimbursement rates to Medicare rates in other contexts. See e.g., Florida Statute § 440.13. This means that its decision not to tie provider reimbursement for emergency services to some percentage of Medicare rates must have been a

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same conclusion, the HMOs must pay providers their billed charges in the absences of a negotiated discount between the parties.

purposeful one. Indeed, the Florida Legislature specifically rebuffed the HMOs' recent attempts to amend the Statute along those very lines. See footnote 1 above. It is clear, then, that Blue Cross' unilateral decision to reimburse providers at 120 percent of Medicare rates cannot comply with § 641.513 (which requires that providers be paid their usual and customary charges or that the parties negotiate a mutually acceptable reimbursement rate). The HMOs are not free to make up their own reimbursement formula (at a lesser amount) when the Statute clearly calls for higher payments to providers. The HMOs are free to negotiate with providers for a lesser amount, but they are not free to simply pay a lower rate by fiat. The Florida Legislature has already precluded this.

CONCLUSION

WHEREFORE, for all the foregoing reasons, *amici curiae*, the Florida Hospital Association, the Florida College Of Emergency Physicians, the Florida Medical Association and the American College of Emergency Physicians, respectfully request that this Court reverse the decision of the Circuit Court. Interpreting the Emergency Services Statute narrowly to deny a private remedy to providers injured by violations thereof would not serve the Statute's purpose or give effect to its provisions and, indeed, would render the Statute meaningless. At the very least, providers should be allowed, under Florida's Declaratory Judgment Act, to seek a statutory interpretation of the payment levels required of HMOs for

emergency care and services thereunder. If providers cannot enforce the very statute that the Florida Legislature passed to ensure that providers' emergency claims would be paid, the Statute would be left a nullity. The Florida Legislature clearly never intended that the Emergency Services Statute be a proverbial right without a remedy.

CERTIFICATE OF SERVICE

We hereby certify that a true and correct copy of the foregoing was furnished via U.S. Mail to the persons on the attached service list, this ____ day of September, 2005.

CERTIFICATE OF COMPLIANCE

We hereby certify that this brief complies with the font requirements set forth in Florida Rule of Appellate Procedure 9.210(a)(2).

Respectfully submitted,

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