

597-2177B-07

Proposed Committee Substitute by the Committee on Banking and Insurance

1 A bill to be entitled
 2 An act relating to motor vehicle insurance;
 3 amending s. 627.736, F.S.; allowing insurers to
 4 limit payments for treatment, care, procedures,
 5 or services for bodily injury covered by
 6 personal injury protection insurance to a
 7 specified percentage of the reimbursement
 8 allowed under the Medicare fee schedule;
 9 allowing payment to be limited to the maximum
 10 allowance under workers' compensation if such
 11 treatment, care, procedure, or service is not
 12 reimbursable under Medicare; prohibiting a
 13 provider from billing or attempting to collect
 14 from an insured amounts in excess of such fee
 15 limitations; repealing s. 19 of chapter
 16 2003-411, Laws of Florida; abrogating the
 17 repeal of the Florida Motor Vehicle No-Fault
 18 Law as provided for in that section; reenacting
 19 ss. 627.730, 627.731, 627.732, 627.733,
 20 627.734, 627.736, 627.737, 627.739, 627.7401,
 21 627.7403, and 627.7405, F.S., the Florida Motor
 22 Vehicle No-Fault Law, and providing for future
 23 review and repeal; providing for application of
 24 the act; providing an effective date.

25
 26 Be It Enacted by the Legislature of the State of Florida:

27
 28 Section 1. Subsection (5) of section 627.736, Florida
 29 Statutes, is amended to read:

30 627.736 Required personal injury protection benefits;
 31 exclusions; priority; claims.--

597-2177B-07

1 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

2 (a)1. Any physician, hospital, clinic, or other person
3 or institution lawfully rendering treatment to an injured
4 person for a bodily injury covered by personal injury
5 protection insurance may charge the insurer and injured party
6 only a reasonable amount pursuant to this section for the
7 services and supplies rendered, and the insurer providing such
8 coverage may pay for such charges directly to such person or
9 institution lawfully rendering such treatment, if the insured
10 receiving such treatment or his or her guardian has
11 countersigned the properly completed invoice, bill, or claim
12 form approved by the office upon which such charges are to be
13 paid for as having actually been rendered, to the best
14 knowledge of the insured or his or her guardian. In no event,
15 however, may such a charge be in excess of the amount the
16 person or institution customarily charges for like services or
17 supplies. With respect to a determination of whether a charge
18 for a particular service, treatment, or otherwise is
19 reasonable, consideration may be given to evidence of usual
20 and customary charges and payments accepted by the provider
21 involved in the dispute, and reimbursement levels in the
22 community and various federal and state medical fee schedules
23 applicable to automobile and other insurance coverages, and
24 other information relevant to the reasonableness of the
25 reimbursement for the service, treatment, or supply.

26 2. The insurer may limit the amount paid to 200
27 percent of the reimbursement allowed for the applicable
28 procedure code as set forth in the Medicare Part A or Medicare
29 Part B participating fee schedule in effect at the time for
30 the region where the treatment, care, procedure, or service is
31 provided. However, if such treatment, care, procedure, or

597-2177B-07

1 service is not reimbursable under the Medicare Part A or
 2 Medicare Part B participating fee schedule, the insurer may
 3 limit payment to the maximum reimbursable allowance under
 4 workers' compensation, as determined under s. 440.13 and rules
 5 adopted thereunder, which are in effect at the time such
 6 treatment, care, procedure, or service is performed. A
 7 treatment, care, procedure, or service that is not
 8 reimbursable under the Medicare fee schedules or that is not
 9 reimbursable under workers' compensation is not reimbursable
 10 by the insurer. However, this subparagraph does not allow the
 11 insurer to apply any limitation on the number of treatments or
 12 other utilization limits that apply under Medicare or workers'
 13 compensation. If an insurer limits payment as authorized by
 14 this subparagraph, the person providing such treatment, care,
 15 procedure, or service may not bill or attempt to collect from
 16 the insured any amounts in excess of such limits, other than
 17 amounts that are not covered by the insured's personal injury
 18 protection coverage due to the deductible, coinsurance amount,
 19 or maximum policy limits.

20 (b)1. An insurer or insured is not required to pay a
 21 claim or charges:

22 a. Made by a broker or by a person making a claim on
 23 behalf of a broker;

24 b. For any service or treatment that was not lawful at
 25 the time rendered;

26 c. To any person who knowingly submits a false or
 27 misleading statement relating to the claim or charges;

28 d. With respect to a bill or statement that does not
 29 substantially meet the applicable requirements of paragraph
 30 (d);

31 e. For any treatment or service that is upcoded, or

597-2177B-07

1 that is unbundled when such treatment or services should be
 2 bundled, in accordance with paragraph (d). To facilitate
 3 prompt payment of lawful services, an insurer may change codes
 4 that it determines to have been improperly or incorrectly
 5 upcoded or unbundled, and may make payment based on the
 6 changed codes, without affecting the right of the provider to
 7 dispute the change by the insurer, provided that before doing
 8 so, the insurer must contact the health care provider and
 9 discuss the reasons for the insurer's change and the health
 10 care provider's reason for the coding, or make a reasonable
 11 good faith effort to do so, as documented in the insurer's
 12 file; and

13 f. For medical services or treatment billed by a
 14 physician and not provided in a hospital unless such services
 15 are rendered by the physician or are incident to his or her
 16 professional services and are included on the physician's
 17 bill, including documentation verifying that the physician is
 18 responsible for the medical services that were rendered and
 19 billed.

20 ~~2. Charges for medically necessary cephalic~~
 21 ~~thermograms, peripheral thermograms, spinal ultrasounds,~~
 22 ~~extremity ultrasounds, video fluoroscopy, and surface~~
 23 ~~electromyography shall not exceed the maximum reimbursement~~
 24 ~~allowance for such procedures as set forth in the applicable~~
 25 ~~fee schedule or other payment methodology established pursuant~~
 26 ~~to s. 440.13.~~

27 ~~3. Allowable amounts that may be charged to a personal~~
 28 ~~injury protection insurance insurer and insured for medically~~
 29 ~~necessary nerve conduction testing when done in conjunction~~
 30 ~~with a needle electromyography procedure and both are~~
 31 ~~performed and billed solely by a physician licensed under~~

597-2177B-07

1 ~~chapter 458, chapter 459, chapter 460, or chapter 461 who is~~
2 ~~also certified by the American Board of Electrodiagnostic~~
3 ~~Medicine or by a board recognized by the American Board of~~
4 ~~Medical Specialties or the American Osteopathic Association or~~
5 ~~who holds diplomate status with the American Chiropractic~~
6 ~~Neurology Board or its predecessors shall not exceed 200~~
7 ~~percent of the allowable amount under the participating~~
8 ~~physician fee schedule of Medicare Part B for year 2001, for~~
9 ~~the area in which the treatment was rendered, adjusted~~
10 ~~annually on August 1 to reflect the prior calendar year's~~
11 ~~changes in the annual Medical Care Item of the Consumer Price~~
12 ~~Index for All Urban Consumers in the South Region as~~
13 ~~determined by the Bureau of Labor Statistics of the United~~
14 ~~States Department of Labor.~~

15 ~~4. Allowable amounts that may be charged to a personal~~
16 ~~injury protection insurance insurer and insured for medically~~
17 ~~necessary nerve conduction testing that does not meet the~~
18 ~~requirements of subparagraph 3. shall not exceed the~~
19 ~~applicable fee schedule or other payment methodology~~
20 ~~established pursuant to s. 440.13.~~

21 ~~5. Allowable amounts that may be charged to a personal~~
22 ~~injury protection insurance insurer and insured for magnetic~~
23 ~~resonance imaging services shall not exceed 175 percent of the~~
24 ~~allowable amount under the participating physician fee~~
25 ~~schedule of Medicare Part B for year 2001, for the area in~~
26 ~~which the treatment was rendered, adjusted annually on August~~
27 ~~1 to reflect the prior calendar year's changes in the annual~~
28 ~~Medical Care Item of the Consumer Price Index for All Urban~~
29 ~~Consumers in the South Region as determined by the Bureau of~~
30 ~~Labor Statistics of the United States Department of Labor for~~
31 ~~the 12-month period ending June 30 of that year, except that~~

597-2177B-07

1 ~~allowable amounts that may be charged to a personal injury~~
2 ~~protection insurance insurer and insured for magnetic~~
3 ~~resonance imaging services provided in facilities accredited~~
4 ~~by the Accreditation Association for Ambulatory Health Care,~~
5 ~~the American College of Radiology, or the Joint Commission on~~
6 ~~Accreditation of Healthcare Organizations shall not exceed 200~~
7 ~~percent of the allowable amount under the participating~~
8 ~~physician fee schedule of Medicare Part B for year 2001, for~~
9 ~~the area in which the treatment was rendered, adjusted~~
10 ~~annually on August 1 to reflect the prior calendar year's~~
11 ~~changes in the annual Medical Care Item of the Consumer Price~~
12 ~~Index for All Urban Consumers in the South Region as~~
13 ~~determined by the Bureau of Labor Statistics of the United~~
14 ~~States Department of Labor for the 12-month period ending June~~
15 ~~30 of that year. This paragraph does not apply to charges for~~
16 ~~magnetic resonance imaging services and nerve conduction~~
17 ~~testing for inpatients and emergency services and care as~~
18 ~~defined in chapter 395 rendered by facilities licensed under~~
19 ~~chapter 395.~~

20 ~~2.6.~~ The Department of Health, in consultation with
21 the appropriate professional licensing boards, shall adopt, by
22 rule, a list of diagnostic tests deemed not to be medically
23 necessary for use in the treatment of persons sustaining
24 bodily injury covered by personal injury protection benefits
25 under this section. The initial list shall be adopted by
26 January 1, 2004, and shall be revised from time to time as
27 determined by the Department of Health, in consultation with
28 the respective professional licensing boards. Inclusion of a
29 test on the list of invalid diagnostic tests shall be based on
30 lack of demonstrated medical value and a level of general
31 acceptance by the relevant provider community and shall not be

597-2177B-07

1 dependent for results entirely upon subjective patient
 2 response. Notwithstanding its inclusion on a fee schedule in
 3 this subsection, an insurer or insured is not required to pay
 4 any charges or reimburse claims for any invalid diagnostic
 5 test as determined by the Department of Health.

6 (c)1. With respect to any treatment or service, other
 7 than medical services billed by a hospital or other provider
 8 for emergency services as defined in s. 395.002 or inpatient
 9 services rendered at a hospital-owned facility, the statement
 10 of charges must be furnished to the insurer by the provider
 11 and may not include, and the insurer is not required to pay,
 12 charges for treatment or services rendered more than 35 days
 13 before the postmark date of the statement, except for past due
 14 amounts previously billed on a timely basis under this
 15 paragraph, and except that, if the provider submits to the
 16 insurer a notice of initiation of treatment within 21 days
 17 after its first examination or treatment of the claimant, the
 18 statement may include charges for treatment or services
 19 rendered up to, but not more than, 75 days before the postmark
 20 date of the statement. The injured party is not liable for,
 21 and the provider shall not bill the injured party for, charges
 22 that are unpaid because of the provider's failure to comply
 23 with this paragraph. Any agreement requiring the injured
 24 person or insured to pay for such charges is unenforceable.

25 2. If, however, the insured fails to furnish the
 26 provider with the correct name and address of the insured's
 27 personal injury protection insurer, the provider has 35 days
 28 from the date the provider obtains the correct information to
 29 furnish the insurer with a statement of the charges. The
 30 insurer is not required to pay for such charges unless the
 31 provider includes with the statement documentary evidence that

597-2177B-07

1 was provided by the insured during the 35-day period
2 demonstrating that the provider reasonably relied on erroneous
3 information from the insured and either:

- 4 a. A denial letter from the incorrect insurer; or
- 5 b. Proof of mailing, which may include an affidavit
6 under penalty of perjury, reflecting timely mailing to the
7 incorrect address or insurer.

8 3. For emergency services and care as defined in s.
9 395.002 rendered in a hospital emergency department or for
10 transport and treatment rendered by an ambulance provider
11 licensed pursuant to part III of chapter 401, the provider is
12 not required to furnish the statement of charges within the
13 time periods established by this paragraph; and the insurer
14 shall not be considered to have been furnished with notice of
15 the amount of covered loss for purposes of paragraph (4)(b)
16 until it receives a statement complying with paragraph (d), or
17 copy thereof, which specifically identifies the place of
18 service to be a hospital emergency department or an ambulance
19 in accordance with billing standards recognized by the Health
20 Care Finance Administration.

21 4. Each notice of insured's rights under s. 627.7401
22 must include the following statement in type no smaller than
23 12 points:

24
25 BILLING REQUIREMENTS.--Florida Statutes provide
26 that with respect to any treatment or services,
27 other than certain hospital and emergency
28 services, the statement of charges furnished to
29 the insurer by the provider may not include,
30 and the insurer and the injured party are not
31 required to pay, charges for treatment or

597-2177B-07

1 services rendered more than 35 days before the
 2 postmark date of the statement, except for past
 3 due amounts previously billed on a timely
 4 basis, and except that, if the provider submits
 5 to the insurer a notice of initiation of
 6 treatment within 21 days after its first
 7 examination or treatment of the claimant, the
 8 statement may include charges for treatment or
 9 services rendered up to, but not more than, 75
 10 days before the postmark date of the statement.

11
 12 (d) All statements and bills for medical services
 13 rendered by any physician, hospital, clinic, or other person
 14 or institution shall be submitted to the insurer on a properly
 15 completed Centers for Medicare and Medicaid Services (CMS)
 16 1500 form, UB 92 forms, or any other standard form approved by
 17 the office or adopted by the commission for purposes of this
 18 paragraph. All billings for such services rendered by
 19 providers shall, to the extent applicable, follow the
 20 Physicians' Current Procedural Terminology (CPT) or Healthcare
 21 Correct Procedural Coding System (HCPCS), or ICD-9 in effect
 22 for the year in which services are rendered and comply with
 23 the Centers for Medicare and Medicaid Services (CMS) 1500 form
 24 instructions and the American Medical Association Current
 25 Procedural Terminology (CPT) Editorial Panel and Healthcare
 26 Correct Procedural Coding System (HCPCS). All providers other
 27 than hospitals shall include on the applicable claim form the
 28 professional license number of the provider in the line or
 29 space provided for "Signature of Physician or Supplier,
 30 Including Degrees or Credentials." In determining compliance
 31 with applicable CPT and HCPCS coding, guidance shall be

597-2177B-07

1 provided by the Physicians' Current Procedural Terminology
 2 (CPT) or the Healthcare Correct Procedural Coding System
 3 (HCPCS) in effect for the year in which services were
 4 rendered, the Office of the Inspector General (OIG),
 5 Physicians Compliance Guidelines, and other authoritative
 6 treatises designated by rule by the Agency for Health Care
 7 Administration. No statement of medical services may include
 8 charges for medical services of a person or entity that
 9 performed such services without possessing the valid licenses
 10 required to perform such services. For purposes of paragraph
 11 (4)(b), an insurer shall not be considered to have been
 12 furnished with notice of the amount of covered loss or medical
 13 bills due unless the statements or bills comply with this
 14 paragraph, and unless the statements or bills are properly
 15 completed in their entirety as to all material provisions,
 16 with all relevant information being provided therein.

17 (e)1. At the initial treatment or service provided,
 18 each physician, other licensed professional, clinic, or other
 19 medical institution providing medical services upon which a
 20 claim for personal injury protection benefits is based shall
 21 require an insured person, or his or her guardian, to execute
 22 a disclosure and acknowledgment form, which reflects at a
 23 minimum that:

24 a. The insured, or his or her guardian, must
 25 countersign the form attesting to the fact that the services
 26 set forth therein were actually rendered;

27 b. The insured, or his or her guardian, has both the
 28 right and affirmative duty to confirm that the services were
 29 actually rendered;

30 c. The insured, or his or her guardian, was not
 31 solicited by any person to seek any services from the medical

597-2177B-07

1 provider;

2 d. That the physician, other licensed professional,
3 clinic, or other medical institution rendering services for
4 which payment is being claimed explained the services to the
5 insured or his or her guardian; and

6 e. If the insured notifies the insurer in writing of a
7 billing error, the insured may be entitled to a certain
8 percentage of a reduction in the amounts paid by the insured's
9 motor vehicle insurer.

10 2. The physician, other licensed professional, clinic,
11 or other medical institution rendering services for which
12 payment is being claimed has the affirmative duty to explain
13 the services rendered to the insured, or his or her guardian,
14 so that the insured, or his or her guardian, countersigns the
15 form with informed consent.

16 3. Countersignature by the insured, or his or her
17 guardian, is not required for the reading of diagnostic tests
18 or other services that are of such a nature that they are not
19 required to be performed in the presence of the insured.

20 4. The licensed medical professional rendering
21 treatment for which payment is being claimed must sign, by his
22 or her own hand, the form complying with this paragraph.

23 5. The original completed disclosure and
24 acknowledgment form shall be furnished to the insurer pursuant
25 to paragraph (4)(b) and may not be electronically furnished.

26 6. This disclosure and acknowledgment form is not
27 required for services billed by a provider for emergency
28 services as defined in s. 395.002, for emergency services and
29 care as defined in s. 395.002 rendered in a hospital emergency
30 department, or for transport and treatment rendered by an
31 ambulance provider licensed pursuant to part III of chapter

597-2177B-07

1 401.

2 7. The Financial Services Commission shall adopt, by
3 rule, a standard disclosure and acknowledgment form that shall
4 be used to fulfill the requirements of this paragraph,
5 effective 90 days after such form is adopted and becomes
6 final. The commission shall adopt a proposed rule by October
7 1, 2003. Until the rule is final, the provider may use a form
8 of its own which otherwise complies with the requirements of
9 this paragraph.

10 8. As used in this paragraph, "countersigned" means a
11 second or verifying signature, as on a previously signed
12 document, and is not satisfied by the statement "signature on
13 file" or any similar statement.

14 9. The requirements of this paragraph apply only with
15 respect to the initial treatment or service of the insured by
16 a provider. For subsequent treatments or service, the provider
17 must maintain a patient log signed by the patient, in
18 chronological order by date of service, that is consistent
19 with the services being rendered to the patient as claimed.
20 The requirements of this subparagraph for maintaining a
21 patient log signed by the patient may be met by a hospital
22 that maintains medical records as required by s. 395.3025 and
23 applicable rules and makes such records available to the
24 insurer upon request.

25 (f) Upon written notification by any person, an
26 insurer shall investigate any claim of improper billing by a
27 physician or other medical provider. The insurer shall
28 determine if the insured was properly billed for only those
29 services and treatments that the insured actually received. If
30 the insurer determines that the insured has been improperly
31 billed, the insurer shall notify the insured, the person

597-2177B-07

1 making the written notification and the provider of its
 2 findings and shall reduce the amount of payment to the
 3 provider by the amount determined to be improperly billed. If
 4 a reduction is made due to such written notification by any
 5 person, the insurer shall pay to the person 20 percent of the
 6 amount of the reduction, up to \$500. If the provider is
 7 arrested due to the improper billing, then the insurer shall
 8 pay to the person 40 percent of the amount of the reduction,
 9 up to \$500.

10 (g) An insurer may not systematically downcode with
 11 the intent to deny reimbursement otherwise due. Such action
 12 constitutes a material misrepresentation under s.
 13 626.9541(1)(i)2.

14 Section 2. Effective January 1, 2009, sections
 15 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737,
 16 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes,
 17 constituting the Florida Motor Vehicle No-Fault Law, are
 18 repealed unless reviewed and reenacted by the Legislature
 19 before that date.

20 Section 3. Section 19 of chapter 2003-411, Laws of
 21 Florida, is repealed, and sections 627.730, 627.731, 627.732,
 22 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401,
 23 627.7403, and 627.7405, Florida Statutes, are reenacted and
 24 shall not stand repealed on October 1, 2007, as provided for
 25 in that section.

26 Section 4. This act shall take effect July 1, 2007,
 27 and shall apply to treatment, care, procedures, or services
 28 rendered or performed on or after that date.

29
 30
 31