

1 A bill to be entitled
2 An act relating to compensation for personal injury or
3 wrongful death arising out of medical injury; amending
4 s. 456.013, F.S.; requiring the boards or the
5 department to require the completion of a course
6 relating to communication of medical errors; providing
7 a directive to the Division of Statutory Revision to
8 divide ch. 766, F.S., into parts; creating part IV of
9 ch. 766, F.S.; creating s. 766.401, F.S.; providing a
10 short title; creating s. 766.402, F.S.; providing
11 definitions; creating s. 766.403, F.S.; providing
12 legislative findings and intent; providing that the
13 remedy created in the part is an exclusive remedy for
14 personal injury or wrongful death arising out of or
15 related to a medical negligence claim; creating s.
16 766.404, F.S.; creating the Patient Compensation
17 System; providing for a governing board; providing for
18 membership and terms of appointment; providing for
19 officers and meetings; limiting compensation of
20 members to certain expenses; providing for an
21 executive director and other staff; providing for
22 offices of medical review, compensation, and quality
23 improvement; providing for committees for medical
24 review and compensation and other purposes as needed
25 and providing their membership and terms; providing
26 requirements for damage payments; providing for
27 independent medical review panels and authorizing a
28 stipend for panelists; providing powers and duties of

29 | the board, staff, committees, offices, and panels;
30 | prohibiting certain conflicts of interest; requiring
31 | rulemaking; creating s. 766.405, F.S.; providing a
32 | process for filing applications; providing an
33 | application filing period; creating s. 766.406, F.S.;
34 | providing for disposition of applications; providing
35 | for notice to providers and insurers; providing for
36 | support of an application pursuant to expedited
37 | medical review; providing for formal medical review
38 | when there is no support of application; providing for
39 | referral to law enforcement of an invalid application
40 | determined to be fraudulent; providing for a
41 | determination of compensation upon prima facie proof
42 | of medical injury; providing that compensation for a
43 | claim shall be offset by any past and future
44 | collateral source payments; providing for payment of
45 | compensation awards, including interest accruing on
46 | unpaid awards; providing for determinations of
47 | malpractice for purposes of a specified constitutional
48 | provision; providing for notice of applications
49 | determined to constitute medical injury for purposes
50 | of professional discipline; creating s. 766.407, F.S.;
51 | providing for review of appeals by an administrative
52 | law judge; providing that determinations of the
53 | administrative law judge are conclusive and binding;
54 | providing for appeal of such determinations; creating
55 | s. 766.408, F.S.; requiring annual contributions from
56 | specified providers to provide administrative

57 | expenses; providing maximum contribution rates;
 58 | specifying payment dates; providing for disciplinary
 59 | proceedings for failure to pay; providing for deposit
 60 | of funds; creating s. 766.409, F.S.; requiring an
 61 | annual report to the Governor and Legislature;
 62 | providing retroactive application; providing
 63 | severability; providing an effective date.
 64 |

65 | Be It Enacted by the Legislature of the State of Florida:
 66 |

67 | Section 1. Subsection (7) of section 456.013, Florida
 68 | Statutes, is amended to read:

69 | 456.013 Department; general licensing provisions.—

70 | (7) The boards, or the department when there is no board,
 71 | shall require the completion of a 2-hour course relating to
 72 | prevention and communication of medical errors as part of the
 73 | licensure and renewal process. The 2-hour course shall count
 74 | towards the total number of continuing education hours required
 75 | for the profession. The course shall be approved by the board or
 76 | department, as appropriate, and shall include a study of root-
 77 | cause analysis, error reduction and prevention, and patient
 78 | safety, and communication of medical errors to patients and
 79 | their families. In addition, the course approved by the Board of
 80 | Medicine and the Board of Osteopathic Medicine shall include
 81 | information relating to the five most misdiagnosed conditions
 82 | during the previous biennium, as determined by the board. If the
 83 | course is being offered by a facility licensed pursuant to
 84 | chapter 395 for its employees, the board may approve up to 1

HB 1233

2012

85 hour of the 2-hour course to be specifically related to error
86 reduction and prevention methods used in that facility.

87 Section 2. The Division of Statutory Revision is directed
88 to designate sections 766.101 through 766.1185, of chapter 766,
89 Florida Statutes, as part I of that chapter, entitled
90 "Litigation Procedures"; sections 766.201 through 766.212 as
91 part II of that chapter, entitled "Voluntary Binding
92 Arbitration"; sections 766.301 through 766.316 as part III of
93 that chapter, entitled "Birth-Related Neurological Injuries";
94 and sections 766.401 through 766.409, as created by this act, as
95 part IV of that chapter, entitled "Patient Compensation System."

96 Section 3. Section 766.401, Florida Statutes, is created
97 to read:

98 766.401 Short title.—This part may be cited as the
99 "Patient Injury Act."

100 Section 4. Section 766.402, Florida Statutes, is created
101 to read:

102 766.402 Definitions.—As used in this part, the term:

103 (1) "Applicant" means a person who files an application
104 under this part requesting the investigation of an alleged
105 occurrence of a medical injury.

106 (2) "Application" means a request for investigation by the
107 Patient Compensation System of an alleged occurrence of a
108 medical injury.

109 (3) "Board" means the Patient Compensation Board as
110 created in s. 766.404.

111 (4) "Collateral source" means any payment made to the
112 applicant, or made on his or her behalf, by or pursuant to:

HB 1233

2012

113 (a) The federal Social Security Act; any federal, state,
114 or local income disability act; or any other public program
115 providing medical expenses, disability payments, or other
116 similar benefits, except as prohibited by federal law.

117 (b) Any health, sickness, or income disability insurance;
118 any automobile accident insurance that provides health benefits
119 or income disability coverage; and any other similar insurance
120 benefits, except life insurance benefits available to the
121 applicant, whether purchased by the applicant or provided by
122 others.

123 (c) Any contract or agreement of any group, organization,
124 partnership, or corporation to provide, pay for, or reimburse
125 the costs of hospital, medical, dental, or other health care
126 services.

127 (d) Any contractual or voluntary wage continuation plan
128 provided by employers or by any other system intended to provide
129 wages during a period of disability.

130 (5) "Committee" means, as the context requires, the
131 Medical Review Committee or the Compensation Committee.

132 (6) "Compensation schedule" means a schedule of damages
133 for medical injuries.

134 (7) "Department" means the Department of Health.

135 (8) "Independent medical review panel" or "panel" means a
136 multidisciplinary panel convened by the chief medical officer to
137 review each application.

138 (9) "Medical injury" means a personal injury or wrongful
139 death due to medical treatment, including a missed diagnosis,
140 which would have been avoided under the care of an experienced

HB 1233

2012

141 specialist provider practicing in the same field of care under
142 the same circumstances or, for a general practitioner provider,
143 an experienced general practitioner provider practicing under
144 the same circumstances. Determination of the validity of a
145 medical injury may only include consideration of an alternate
146 course of treatment if the harm could have been avoided through
147 a different but equally effective manner with respect to the
148 treatment of the underlying condition. The term does not include
149 an injury or wrongful death:

150 (a) That is the consequence of a necessary procedure to
151 diagnose or treat an illness or an injury which, if left
152 untreated, would be directly life-threatening or lead to severe
153 disability;

154 (b) Caused by a drug, as defined in s. 499.003, unless the
155 injury or wrongful death is due to a prescription error or
156 administration error; or

157 (c) Caused by a device, as defined in s. 499.003.

158 (10) "Office" means, as the context requires, the Office
159 of Compensation, the Office of Medical Review, or the Office of
160 Quality Improvement.

161 (11) "Panelist" means a hospital administrator, a person
162 licensed under chapter 458, chapter 459, chapter 460, part I of
163 chapter 464, or chapter 466, or any other person involved in the
164 management of a health care facility as deemed by the board to
165 be appropriate.

166 (12) "Patient Compensation System" means the organization
167 created pursuant to s. 766.404.

168 (13) "Provider" means a birth center licensed under

169 chapter 383; any facility licensed under chapter 390, chapter
 170 395, chapter 400, or chapter 429; a home health agency or nurse
 171 registry licensed under part III of chapter 400; a health care
 172 services pool registered under part IX of chapter 400; any
 173 person licensed under s. 401.27 or chapter 457, chapter 458,
 174 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
 175 chapter 464, chapter 465, chapter 466, chapter 467, part I, part
 176 II, part III, part IV, part V, part X, part XIII, or part XIV of
 177 chapter 468, chapter 478, part III of chapter 483, or chapter
 178 486; a clinical lab licensed under part I of chapter 483; a
 179 multiphasic health testing center licensed under part II of
 180 chapter 483; a health maintenance organization certificated
 181 under part I of chapter 641; a blood bank; a plasma center; an
 182 industrial clinic; a renal dialysis facility; or a professional
 183 association partnership, corporation, joint venture, or other
 184 association for professional activity by health care providers.

185 Section 5. Section 766.403, Florida Statutes, is created
 186 to read:

187 766.403 Legislative findings and intent; exclusive
 188 remedy.—

189 (1) LEGISLATIVE FINDINGS.—

190 (a) The Legislature finds that the lack of legal
 191 representation, and, thus, compensation, for the vast majority
 192 of patients with legitimate injuries is creating an access to
 193 courts crisis.

194 (b) The Legislature finds that seeking compensation
 195 through medical malpractice litigation is a costly and
 196 protracted process to the extent that that legal counsel may

HB 1233

2012

197 only afford to finance a small number of legitimate claims.

198 (c) The Legislature finds that, even for patients who are
199 able to obtain legal representation, the delay in obtaining
200 compensation is averaging approximately 5 years, creating a
201 significant hardship for patients and their caregivers who often
202 need access to immediate care and compensation.

203 (d) The Legislature finds that, because of continued
204 exposure to liability, an overwhelming majority of physicians
205 practice defensive medicine by ordering unnecessary tests and
206 procedures, increasing the cost of health care for individuals
207 covered by public and private health insurance coverage and
208 exposing patients to unnecessary clinical risks.

209 (e) The Legislature finds that a significant percentage of
210 physicians are continuing to retire from practice as a result of
211 the cost and risk of medical liability in this state.

212 (f) The Legislature finds that recruiting physicians to
213 this state and ensuring that physicians currently practicing in
214 this state continue their practice is an overwhelming public
215 necessity.

216 (2) LEGISLATIVE INTENT.—

217 (a) The Legislature intends to create an alternative to
218 medical malpractice litigation whereby patients are fairly and
219 expeditiously compensated for avoidable medical injuries. As
220 provided in this part, this alternative is intended to
221 significantly reduce the practice of defensive medicine, thereby
222 reducing health care costs, increasing the number of physicians
223 practicing in this state, and providing patients fair and timely
224 compensation without the expense and delay of the court system.

HB 1233

2012

225 The Legislature intends that the provisions of this part apply
226 to all health care facilities and health care practitioners who
227 are either insured or self-insured against claims for medical
228 malpractice.

229 (b) The Legislature intends that an application filed
230 under this part does not constitute a claim for medical
231 malpractice and any action on such an application does not
232 constitute a judgment or adjudication for medical malpractice,
233 and, therefore, professional liability carriers are not
234 obligated to report such applications or actions on such
235 applications to the National Practitioner Data Bank.

236 (c) The Legislature intends that the definition of the
237 term "medical injury" be construed to encompass a broader range
238 of personal injuries as compared to a negligence standard, such
239 that a greater number of applications qualify for compensation
240 under this part as compared to claims filed under a negligence
241 standard.

242 (d) The Legislature intends that because the Patient
243 Compensation System has the primary duty to determine the
244 validity and compensation of each application, an insurer shall
245 not be subject to a statutory or common law bad faith cause of
246 action relating to an application filed under this part.

247 (3) EXCLUSIVE REMEDY.—With the exception of part III, the
248 rights and remedies granted by this part on account of a
249 personal injury or wrongful death exclude all other rights and
250 remedies of the applicant, his or her personal representative,
251 parents, dependents, and the next of kin, at common law or as
252 provided in general law, against any provider directly involved

253 in providing the medical treatment from which such injury or
 254 death occurred, arising out of or related to a medical
 255 negligence claim, whether in tort or in contract, with respect
 256 to such injury. Notwithstanding any other law, this part applies
 257 exclusively to applications submitted under this part. An
 258 applicant whose injury falls within the scope of part III may
 259 not file an application under this part.

260 Section 6. Section 766.404, Florida Statutes, is created
 261 to read:

262 766.404 Patient Compensation System; board; committees.—

263 (1) PATIENT COMPENSATION SYSTEM.—The Patient Compensation
 264 System is created and shall be administratively housed within
 265 the department. The Patient Compensation System is a separate
 266 budget entity that is responsible for its administrative
 267 functions and is not subject to control, supervision, or
 268 direction by the department in any manner. The Patient
 269 Compensation System shall administer this part.

270 (2) PATIENT COMPENSATION BOARD.—The Patient Compensation
 271 Board is established to govern the Patient Compensation System.

272 (a) Members.—The board shall be composed of 11 members who
 273 represent the medical, legal, patient, and business communities
 274 from diverse geographic areas throughout the state. Members of
 275 the board shall be appointed as follows:

276 1. Five members shall be appointed by, and serve at the
 277 pleasure of, the Governor, one of whom shall be an allopathic or
 278 osteopathic physician who actively practices in this state, one
 279 of whom shall be an executive in the business community, one of
 280 whom shall be a hospital administrator, one of whom shall be a

281 certified public accountant who actively practices in this
282 state, and one of whom shall be a member of The Florida Bar.

283 2. Three members shall be appointed by, and serve at the
284 pleasure of, the President of the Senate, one of whom shall be
285 an allopathic or osteopathic physician who actively practices in
286 this state and one of whom shall be a patient advocate.

287 3. Three members shall be appointed by, and serve at the
288 pleasure of, the Speaker of the House of Representatives, one of
289 whom shall be an allopathic or osteopathic physician who
290 actively practices in this state and one of whom shall be a
291 patient advocate.

292 (b) Terms of appointment.—Each member shall be appointed
293 for a 4-year term. For the purpose of providing staggered terms,
294 of the initial appointments, the five members appointed by the
295 Governor shall be appointed to 2-year terms and the remaining
296 six members shall be appointed to 3-year terms. If a vacancy
297 occurs on the board before the expiration of a term, the
298 original appointing authority shall appoint a successor to serve
299 the unexpired portion of the term.

300 (c) Chair and vice chair.—The board shall annually elect
301 from its membership one member to serve as chair of the board
302 and one member to serve as vice chair.

303 (d) Meetings.—The first meeting of the board shall be held
304 no later than August 1, 2012. Thereafter, the board shall meet
305 at least quarterly upon the call of the chair. A majority of the
306 board members constitutes a quorum. Meetings may be held by
307 teleconference, webconference, or other electronic means.

308 (e) Compensation.—Members of the board and the committees

HB 1233

2012

309 shall serve without compensation but may be reimbursed for per
310 diem and travel expenses for required attendance at board and
311 committee meetings in accordance with s. 112.061.

312 (f) Powers and duties of the board.—The board shall have
313 the following powers and duties:

314 1. Ensuring the operation of the Patient Compensation
315 System in accordance with applicable federal and state laws,
316 rules, and regulations.

317 2. Entering into contracts as necessary to administer this
318 part.

319 3. Employing an executive director and other staff as are
320 necessary to perform the functions of the Patient Compensation
321 System, except that the Governor shall appoint the initial
322 executive director.

323 4. Approving the hiring of a chief compensation officer
324 and a chief medical officer, as recommended by the executive
325 director.

326 5. Approving a schedule of compensation for medical
327 injuries, as recommended by the Compensation Committee.

328 6. Approving medical review panelists, as recommended by
329 the Medical Review Committee.

330 7. Approving an annual budget.

331 8. Annually approving provider contribution amounts.

332 (g) Powers and duties of staff.—The executive director
333 shall oversee the operation of the Patient Compensation System
334 in accordance with this part. The following staff shall report
335 directly to and serve at the pleasure of the executive director:

336 1. Advocacy director.—The advocacy director shall ensure

HB 1233

2012

337 that each applicant is provided high quality individual
338 assistance throughout the application process, from initial
339 filing to disposition of the application.

340 2. Chief compensation officer.—The chief compensation
341 officer shall manage the Office of Compensation. The chief
342 compensation officer shall recommend to the Compensation
343 Committee a compensation schedule for each type of injury. The
344 chief compensation officer may not be a licensed physician or an
345 attorney.

346 3. Chief financial officer.—The chief financial officer
347 shall be responsible for overseeing the financial operations of
348 the Patient Compensation System, including the annual
349 development of a budget.

350 4. Chief legal officer.—The chief legal officer shall
351 represent the Patient Compensation System in all contested
352 applications, oversee the operation of the Patient Compensation
353 System to ensure compliance with established procedures, and
354 ensure adherence to all applicable federal and state laws,
355 rules, and regulations.

356 5. Chief medical officer.—The chief medical officer shall
357 be a physician licensed under chapter 458 or chapter 459 who
358 shall manage the Office of Medical Review. The chief medical
359 officer shall recommend to the Medical Review Committee a
360 qualified list of multidisciplinary panelists for independent
361 medical review panels. In addition, the chief medical officer
362 shall convene independent medical review panels as necessary to
363 review applications.

364 6. Chief quality officer.—The chief quality officer shall

HB 1233

2012

365 manage the Office of Quality Improvement.

366 (3) OFFICES.—The following offices are established within
367 the Patient Compensation System:

368 (a) Office of Medical Review.—The chief medical officer
369 shall manage the Office of Medical Review. The Office of Medical
370 Review shall evaluate and, as necessary, investigate all
371 applications in accordance with this part. For the purpose of an
372 investigation of an application, the office may administer
373 oaths, take depositions, issue subpoenas, compel the attendance
374 of witnesses and the production of papers, documents, and other
375 evidence, and obtain patient records pursuant to the applicant's
376 release of protected health information.

377 (b) Office of Compensation.—The chief compensation officer
378 shall manage the Office of Compensation. The office shall
379 allocate compensation for each application in accordance with
380 the compensation schedule.

381 (c) Office of Quality Improvement.—The chief quality
382 officer shall manage the Office of Quality Improvement. The
383 office shall regularly review applications data to conduct root
384 cause analyses and develop and disseminate best practices based
385 on such reviews.

386 (4) COMMITTEES.—The board shall create a Medical Review
387 Committee and a Compensation Committee. The board may create
388 additional committees as necessary to assist in the performance
389 of its duties and responsibilities.

390 (a) Members.—Each committee shall be composed of three
391 board members chosen by a majority vote of the board.

392 1. The Medical Review Committee shall be composed of two

HB 1233

2012

393 physicians and a board member who is not an attorney. The board
394 shall designate a physician committee member as chair of the
395 committee.

396 2. The Compensation Committee shall be composed of a
397 certified public accountant and two board members who are not
398 physicians or attorneys. The certified public accountant shall
399 serve as chair of the committee.

400 (b) Terms of appointment.—Members of each committee shall
401 serve 2-year terms, within their respective terms as board
402 members. If a vacancy occurs on a committee, the board shall
403 appoint a successor to serve the unexpired portion of the term.
404 A committee member who is removed or resigns from the board
405 shall be removed from the committee.

406 (c) Chair and vice chair.—The board shall annually
407 designate a chair and vice chair of each committee in accordance
408 with this subsection.

409 (d) Meetings.—Each committee shall meet at least quarterly
410 or at the specific direction of the board. Meetings may be held
411 by teleconference, webconference, or other electronic means.

412 (e) Powers and duties.—

413 1. The Medical Review Committee shall recommend to the
414 board a comprehensive, multidisciplinary list of panelists who
415 shall serve on the independent medical review panels as needed.

416 2. The Compensation Committee shall, in consultation with
417 the chief compensation officer, recommend to the board a
418 compensation schedule. The initial compensation schedule shall
419 be formulated such that the aggregate cost of medical
420 malpractice and the aggregate of provider contributions are

HB 1233

2012

421 equal to, or less than, the prior fiscal year aggregate cost of
422 medical malpractice. In addition, damage payments for each
423 injury shall be no less than the average indemnity payment
424 reported by the Physician Insurers Association of America or its
425 successor organization for like injuries with like severity.
426 Thereafter, the compensation schedule shall be annually reviewed
427 and, if necessary, revised to ensure that a projected increase
428 in the upcoming fiscal year aggregate cost of medical
429 malpractice, including insured and self-insured providers, does
430 not exceed the percentage change from the prior fiscal year in
431 the medical care component of the Consumer Price Index for All
432 Urban Consumers. Damage payments for each medical injury shall
433 be apportioned among multiple providers, if applicable,
434 conforming to historical apportionment among multiple providers
435 reported by the Physician Insurers Association of America or its
436 successor organization for like injuries with like severity.

437 (5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical
438 officer shall convene an independent medical review panel to
439 evaluate whether an application constitutes medical injury. Each
440 panel shall be composed of an odd number of at least three
441 panelists chosen from the list of panelists recommended by the
442 Medical Review Committee and approved by the board, and shall be
443 convened upon the call of the chief medical officer. Each
444 panelist shall be paid a stipend as determined by the board for
445 his or her service. In order to expedite the review of
446 applications, the chief medical officer may, whenever
447 practicable, group related applications together for
448 consideration by a single panel.

449 (6) CONFLICTS OF INTEREST.—A board member, panelist, or
450 employee of the Patient Compensation System may not engage in
451 any conduct that constitutes a conflict of interest. For
452 purposes of this subsection, a conflict of interest exists in a
453 situation in which the private interest of a board member,
454 panelist, or employee could influence his or her judgment in the
455 performance of his or her duties under this part. A board
456 member, panelist, or employee must immediately disclose in
457 writing the presence of a conflict of interest when the board
458 member, panelist, or employee knows or should know that the
459 factual circumstances surrounding a particular application
460 constitutes or constituted a conflict of interest. A board
461 member, panelist, or employee who violates this subsection is
462 subject to disciplinary action as determined by the board. A
463 conflict of interest includes, but is not limited to:

464 (a) Any conduct that would lead a reasonable person having
465 knowledge of all of the circumstances to conclude that a
466 panelist or employee is biased against or in favor of an
467 applicant.

468 (b) Participation in any application in which the board
469 member, panelist, or employee, or the parent, spouse, or child
470 of a board member, panelist, or employee has a financial
471 interest.

472 (7) RULEMAKING.—The board shall adopt rules pursuant to
473 ss. 120.536(1) and 120.54 to implement and administer this part,
474 which shall include rules addressing:

475 (a) The application process, including forms necessary to
476 collect relevant information from applicants.

HB 1233

2012

477 (b) Disciplinary procedures for a board member, panelist,
478 or employee who violates the conflicts of interest provisions of
479 this part.

480 (c) Stipends paid to panelists for their service on an
481 independent medical review panel, which stipends may be scaled
482 in accordance with the relative scarcity of the provider's
483 specialty, if applicable.

484 Section 7. Section 766.405, Florida Statutes, is created
485 to read:

486 766.405 Filing of applications.-

487 (1) CONTENT.-In order to obtain compensation for medical
488 injury under this part, an applicant must file an application
489 with the Patient Compensation System. The advocacy director
490 shall assist each applicant in filing an application and shall
491 regularly provide status reports to the applicant regarding his
492 or her application. The application must include:

493 (a) The name and address of the applicant or his or her
494 representative and the basis of the representation.

495 (b) The name and address of any provider who provided
496 medical treatment allegedly resulting in the medical injury.

497 (c) A brief statement of the facts and circumstances
498 surrounding the personal injury or wrongful death that gave rise
499 to the application.

500 (d) An authorization for release to the Office of Medical
501 Review of all protected health information that is potentially
502 relevant to the application.

503 (e) Any other information that the applicant believes will
504 be beneficial to the investigatory process, including the names

HB 1233

2012

505 of potential witnesses.

506 (f) Documentation of any applicable private or
507 governmental source of services or reimbursement relative to the
508 personal injury or wrongful death.

509 (2) INCOMPLETE APPLICATIONS.—If an application is not
510 complete, the Patient Compensation System shall, within 30 days
511 after the receipt of the initial application, notify the
512 applicant in writing of any errors or omissions. An applicant
513 shall have 30 days within which to correct the errors or
514 omissions in the initial application.

515 (3) LIMITATION ON APPLICATIONS.—Any application that is
516 filed more than 4 years after the personal injury or wrongful
517 death giving rise to the application is barred.

518 Section 8. Section 766.406, Florida Statutes, is created
519 to read:

520 766.406 Disposition of applications.—

521 (1) INITIAL MEDICAL REVIEW.—The Office of Medical Review
522 shall, within 10 days after receipt of a completed application,
523 determine whether the application, prima facie, constitutes a
524 medical injury.

525 (a) If the Office of Medical Review determines that the
526 application, prima facie, constitutes a medical injury, the
527 office shall immediately notify, by registered or certified
528 mail, each provider named in the application and, for providers
529 that are not self-insured, the insurer that provides coverage
530 for the provider. The notification shall inform the provider
531 that he or she may support the application to expedite the
532 processing of the application. A provider shall have 15 days

HB 1233

2012

533 after the receipt of notification of an application to support
534 the application. If the provider supports the application, the
535 Office of Medical Review shall review the application in
536 accordance with subsection (2).

537 (b) If the Office of Medical Review determines that the
538 application does not, prima facie, constitute a medical injury,
539 the office shall send a rejection letter to the applicant by
540 registered or certified mail, which shall inform the applicant
541 of his or her right of appeal. The applicant shall have 15 days
542 after the receipt of the letter in which to appeal the
543 determination of the office pursuant to s. 766.407.

544 (2) EXPEDITED MEDICAL REVIEW.—An application that is
545 supported by a provider in accordance with subsection (1) shall
546 be reviewed by the Office of Medical Review, within 30 days
547 after notification of the provider's support of the application,
548 to determine the validity of the application. If Office of
549 Medical Review finds that the application is valid, the Office
550 of Compensation shall determine an award of compensation in
551 accordance with subsection (4). If the Office of Medical Review
552 finds that the application is not valid, the office shall
553 immediately notify the applicant of the rejection of the
554 application and, in the case of fraud, the office shall
555 immediately notify relevant law enforcement authorities.

556 (3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review
557 determines that the application, prima facie, constitutes a
558 medical injury, and the provider does not elect to support the
559 application, the office shall complete a thorough investigation
560 of the application within 60 days after the determination by the

HB 1233

2012

561 office. Within 15 days after the completion of the
562 investigation, the chief medical officer shall allow the
563 applicant and the provider to access records, statements, and
564 other information obtained in the course of its investigation,
565 in accordance with relevant state and federal laws. Within 30
566 days after the completion of the investigation, convene an
567 independent medical review panel to determine whether the
568 application constitutes a medical injury. The independent
569 medical review panel shall have access to all redacted
570 information obtained by the office in the course of its
571 investigation of the application, and shall conclude its
572 determination within 10 days after the convening of the panel.
573 The standard of review shall be a preponderance of the evidence.

574 (a) If the independent medical review panel determines
575 that the application constitutes a medical injury, the Office of
576 Medical Review shall immediately notify the provider by
577 registered or certified mail of the right to appeal the finding
578 of the office. The provider shall have 15 days after the receipt
579 of the letter in which to appeal the determination of the panel
580 to s. 766.407.

581 (b) If the independent medical review panel determines
582 that the application does not constitute a medical injury, the
583 Office of Medical Review shall send a rejection letter to the
584 applicant by registered or certified mail, which shall explain,
585 in detail, the reasons for the rejection of the application and
586 the process to appeal the determination of the panel. The
587 applicant shall have 15 days from the receipt of the letter to
588 appeal the determination of the panel pursuant to s. 766.407.

HB 1233

2012

589 (4) COMPENSATION REVIEW.—If an independent medical review
590 panel finds that an application constitutes a medical injury
591 pursuant to subsection (3), and all appeals of that finding have
592 been exhausted by the provider pursuant to s. 766.407, the
593 Office of Compensation shall, within 30 days after either the
594 finding of the panel or the exhaustion of all appeals of that
595 finding, whichever occurs later, determine an award of
596 compensation in accordance with the compensation schedule and
597 the findings of the panel. The office shall, by registered or
598 certified mail, inform the applicant of the amount of
599 compensation and the process to appeal the determination of the
600 office. The applicant shall have 15 days after receipt of the
601 letter to appeal the determination of the office pursuant to s.
602 766.407.

603 (5) LIMITATION ON COMPENSATION.—Compensation for each
604 application shall be offset by any past and future collateral
605 source payments and shall be paid by periodic payments.

606 (6) PAYMENT OF COMPENSATION.—Within 14 days after either
607 the acceptance of compensation by the applicant or the
608 conclusion of all appeals pursuant to s. 766.407, the provider,
609 or for a provider who has insurance coverage, the insurer, shall
610 pay the compensation award. Beginning 45 days after the
611 acceptance of compensation by the applicant or the conclusion of
612 all appeals pursuant to s. 766.407, whichever occurs later, an
613 unpaid award shall begin to accrue interest at the rate of 18
614 percent per year. An applicant may petition the circuit court
615 for enforcement of an award under this part.

616 (7) DETERMINATION OF MEDICAL MALPRACTICE.—For purposes of

617 s. 26, Art. X of the State Constitution, a physician who is the
 618 subject of an application under this part must be found to have
 619 committed medical malpractice only upon a specific finding of
 620 the Board of Medicine or Board of Osteopathic medicine, as
 621 applicable, in accordance with s. 456.50.

622 (8) PROFESSIONAL BOARD NOTICE.—The Patient Compensation
 623 System shall provide the department with electronic access to
 624 applications determined to constitute a medical injury related
 625 to persons licensed under chapter 458, chapter 459, chapter 460,
 626 part I of chapter 464, or chapter 466. The department shall
 627 review such applications to determine whether any of the
 628 incidents that resulted in the application potentially involved
 629 conduct by the licensee that is subject to disciplinary action,
 630 in which case s. 456.073 applies.

631 Section 9. Section 766.407, Florida Statutes, is created
 632 to read:

633 766.407 Review by administrative law judge; appellate
 634 review.—

635 (1) An administrative law judge shall hear and determine
 636 appeals filed pursuant to s. 766.406 and shall exercise the full
 637 power and authority granted to him or her in chapter 120, as
 638 necessary, to carry out the purposes of such sections. The
 639 administrative law judge shall be limited in his or her review
 640 to determining whether the Office of Medical Review, the
 641 independent medical review panel, or the Office of Compensation,
 642 as appropriate, has faithfully followed the requirements of this
 643 part and rules adopted thereunder in reviewing applications. If
 644 the administrative law judge determines that such requirements

645 were not followed in reviewing an application, he or she shall
 646 require the chief medical officer to reconvene the original
 647 panel or convene a new panel or require the Office of
 648 Compensation to redetermine the compensation amount in
 649 accordance with the determination by the judge.

650 (2) A determination by an administrative law judge under
 651 this section regarding the faithful following of the
 652 requirements of this part and rules adopted thereunder shall be
 653 conclusive and binding as to all questions of fact. Such
 654 determination with findings of fact and conclusions of law shall
 655 be provided to the applicant and the provider. An applicant or
 656 provider may appeal determination of the administrative law
 657 judge to a district court of appeal. Appeals shall be filed in
 658 accordance with rules of procedure adopted by the Supreme Court
 659 for the review of such orders.

660 Section 10. Section 766.408, Florida Statutes, is created
 661 to read:

662 766.408 Expenses of administration.—

663 (1) The board shall annually determine a contribution to
 664 be paid by each provider for the expense of the administration
 665 of this part. The contribution amount shall be determined by
 666 January 1 of each year and shall be based on the anticipated
 667 expenses of the administration of this part for the next state
 668 fiscal year.

669 (2) The contribution rate may not exceed the following
 670 amounts:

671 (a) For an individual licensed under s. 401.27, a
 672 chiropractic assistant licensed under chapter 460, or an

HB 1233

2012

673 individual licensed under chapter 461, chapter 462, chapter 463,
674 chapter 464, with the exception of a certified registered nurse
675 anesthetist, chapter 465, chapter 466, chapter 467, part I, part
676 II, part III, part IV, part V, part X, part XIII, or part IV of
677 chapter 468, chapter 478, part III of chapter 483, or chapter
678 486, \$100 per licensee.

679 (b) For an anesthesiology assistant or physician assistant
680 licensed under chapter 458 or chapter 459 or a certified
681 registered nurse anesthetist certified under part I of chapter
682 464, \$250 per licensee.

683 (c) For a physician licensed under chapter 458, chapter
684 459, or chapter 460, \$600 per licensee. The contribution for the
685 initial fiscal year for a licensee described in this paragraph
686 shall be \$500 per licensee.

687 (d) For a facility licensed under part II of chapter 400
688 or a facility licensed under part I of chapter 429, \$100 per
689 bed.

690 (e) For a facility licensed under chapter 395, \$200 per
691 bed. The contribution for the initial fiscal year shall be \$100
692 per bed.

693 (f) For any other provider not otherwise described in this
694 subsection, \$2,500 per registrant or licensee.

695 (3) The contribution determined under this section is
696 payable by each provider upon notice delivered on or after July
697 1 of the next state fiscal year. Each provider shall pay the
698 contribution amount within 30 days after the date that notice is
699 delivered to the provider. If any provider fails to pay the
700 contribution determined under this section within 30 days after

701 such notice, the board shall notify the provider by certified or
 702 registered mail that the provider's license shall be subject to
 703 revocation if the contribution is not paid within 60 days after
 704 the date of the original notice.

705 (4) A provider who fails to pay the contribution amount
 706 determined under this section within 60 days after receipt of
 707 the original notice is subject to licensure revocation action by
 708 the department, the Agency for Health Care Administration, or
 709 the relevant regulatory board, as appropriate.

710 (5) All amounts collected under this section shall be paid
 711 into the Patient Compensation Trust Fund established in s.
 712 766.410.

713 Section 11. Section 766.409, Florida Statutes, is created
 714 to read:

715 766.409 Annual report.—The board shall annually, by
 716 October 1, submit to the Governor, the President of the Senate,
 717 and the Speaker of the House of Representatives a report that
 718 describes the filing and disposition of applications in the
 719 prior fiscal year. The report shall include, in the aggregate,
 720 the number of applications, the disposition of such
 721 applications, and the compensation awarded.

722 Section 12. It is the intent of the Legislature to apply
 723 this act to prior medical incidents for which a notice of intent
 724 to initiate litigation has not been mailed before the effective
 725 date of this act.

726 Section 13. If any provision of this act or its
 727 application to any person or circumstance is held invalid, the
 728 invalidity does not affect other provisions or applications of

HB 1233

2012

729 | the act which may be given effect without the invalid provision
730 | or application, and to this end the provisions of this act are
731 | severable.

732 | Section 14. This act shall take effect upon becoming a
733 | law.