SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1092

SPONSOR: Criminal Justice and Banking and Insurance Committees and Senator Campbell

SUBJECT: Insurance Fraud

DATE: April 23, 2001 REVISED: 4/24/01

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.	Erickson	Cannon	CJ	Favorable/CS
3.	Pingree	Beck	APJ	Fav / 1 amendment
4.			AP	
5.				
6.				

I. Summary:

Under the Florida Motor Vehicle No-Fault law, motor vehicle owners are required to maintain $10,000 of personal injury protection (PIP) coverage. Subject to co-payments and other restrictions, PIP insurance provides compensation for bodily injuries to the insured driver and passengers regardless of who is at fault in an accident. This coverage also provides the policyholder with immunity from liability for economic damages up to the policy limits and for non-economic damages (pain and suffering) for most injuries. Property damage liability coverage of $10,000 is also required which pays for the physical damage expenses caused by the insured to third parties in the accident.

In September 2000, the Fifteenth Statewide Grand Jury examined fraud relating to PIP insurance and made seven recommendations to the Legislature. Five of the recommendations are addressed in this bill, while two of the recommendations are addressed in CS/SB 1466 (crash reports).[1] In summary, the five recommendations provide for the following:

- Require regulation and licensure of medical facilities;
- Consider adopting a fee schedule for reimbursement under PIP similar to workers' compensation provisions;
- Provide insurers an additional 30 days to pay PIP claims, at least in instances where the insurer certifies that the claim be reviewed for fraud;
- Make all charges for magnetic resonance imaging (MRIs) unenforceable, unless such charges are billed/collected by 100 percent owner/lessee. This will remove incentives for brokering;

[1] The two Grand Jury recommendations call for prohibiting the release of accident reports with specified exceptions and increasing the penalty for persons who unlawfully obtain accident reports.

- Provide that an insurer or PIP accident victim does not have to pay for services rendered by any provider or attorney who has solicited the victim.

The Committee Substitute for Committee Substitute for Senate Bill 1092 addresses the five recommendations in the Grand Jury report and related issues as follows:

- Requires certain clinics to register with the Department of Health and employ a physician as medical director with specified exceptions. Provides for responsibilities of the medical director and mandates penalties for unregistered clinics as well as disciplining licensed health care practitioners who violate certain provisions.
- Adds five additional diagnostic tests to the one now subject to the workers' compensation fee schedule and limit the maximum reimbursement for medically necessary magnetic resonance imaging (MRIs) services to 75 percent of the "Ingenix Customized Fee Analyzer." Hospitals are excluded from this provision.
- Provides a definition of "broker" and state, with certain exceptions, that insurance companies are not required to pay claims made by brokers or by persons making claims on behalf of brokers. Also defines "medically necessary" as used in the motor vehicle no-fault law.
- Allows an insurer an additional 30 days from the date a claim would otherwise become overdue to refer such claim for investigation to the Department of Insurance (Fraud Division). Such referral must be made within 30 days from the date of the claim. However, the insurer may only refer such claims when it has "reasonable evidence" to establish that the claim violates s. 626.989, F.S., or is a criminal act involving insurance fraud, including a violation of s. 817.234, F.S., or s. 817.505, F.S., or kickbacks under s. 456.054, F.S., associated with a claim for PIP benefits in accordance with s. 627.736, F.S.
- Mandates "presuit notice" as a condition precedent to filing an action for overdue claims against an insurer. However, such notice only applies to claims that are overdue and not more than 45 days after the insurer's receipt of written notice of the fact of a covered loss and of the amount of that loss. Clarifies that the notice of intent to initiate litigation may not be sent until a claim is overdue and specify the notice is to be sent to the insurer at the address to which the claim in issue was sent and to the insurance adjuster. This provision allows insurers 7 business days after receipt of a notice of an overdue claim to pay the claim without being potentially subject to payment of attorney's fees.
- Creates a civil cause of action to allow insurers to sue a person who, in connection with a claim for PIP benefits, is found guilty of or plead guilty or nolo contendere to specified violations, regardless of adjudication of guilt.
- Provides minimum mandatory sentences for persons who solicit persons involved in motor vehicle accidents, insurance fraud, and patient brokering.
- Expands immunity from civil liability for individuals reporting insurance fraud to the Department of Insurance.
- Provides that the "spiritual healing" provision does not affect determinations of what other services or procedures are medically necessary.
- Eliminates the medical payments provision which currently requires that medical payment insurance fill the 20 percent PIP co-insurance;

- Changes the interest rate for overdue payments from a fixed rate to the rate established by the Comptroller under s. 55.03, F.S.
- Helps to remedy the current practice of insurers utilizing "paper" independent medical examinations (IMEs) by requiring "valid" reports by experienced physicians or a physical examination by a physician who meets certain active practice criteria. Also provides that such report may not be modified by anyone other than the physician.
- Allows providers up to 75 days under specified conditions to submit a statement of charges to insurance companies.

The bill substantially amends the following sections of the Florida Statutes: 626.989, 627.732, 627.736, 627.739, 817.234, 817.505, and 324.021. The bill creates section 456.0375, Florida Statutes.

II. Present Situation:

A. Grand Jury Findings--Insurance Fraud Related To Personal Injury Protection Insurance

The Fifteenth Statewide Grand Jury issued a report in September 2000, examining insurance fraud related to personal injury protection coverage.[2] The Grand Jury report defined PIP fraud as follows: *1) the illegal solicitation of accident victims for the purpose of filing for PIP benefits and motor vehicle tort claims; 2) brokering patients between doctors, lawyers and diagnostic facilities, as well as attendant fraud, which can include the filing of false claims; 3) billing insurers for treatment not rendered; 4) using phony diagnostic tests or misusing legitimate tests; 5) inflating charges for diagnostic tests or procedures through brokers; and 6) filing fraudulent motor vehicle tort lawsuits.* According to the Grand Jury, "certain people have turned the $10,000 of personal injury protection coverage into their own personal slush fund."

The Statewide Grand Jury made seven recommendations to the Florida Legislature:

- Require the regulation and licensing of all medical facilities.
- Consider adopting a fee schedule for reimbursement of medical services under the personal injury protection statute.
- Give insurers an additional 30 days to pay personal injury protection claims, at least in those instances where the insurer certifies that the claim is being reviewed for possible fraud.
- Make all charges for magnetic resonance imaging (MRIs) tests unenforceable unless the charges are billed and collected by the 100-percent owner or the 100-percent lessee of the equipment used to perform such services. This will remove incentives for brokering.
- Amend s. 817.234(8), F.S., to state that no insurer or auto accident victim is obligated to pay for any services rendered by any medical provider or attorney who has solicited the victim or caused the victim to be solicited contrary to Florida Statutes.

[2] To view the Grand Jury report and recommendations in its entirety, go to the web site for the Statewide Prosecutor's office under the Attorney General (http://legal.firn.edu/swp/jury/fifteenth.html) and select the Report on Insurance Fraud Related To Personal Injury Protection.

- Prohibit the release of accident reports to anyone other than the victim, their insurance company, a radio or TV station licensed by the FCC, or a professional journalist.
- Increase the penalty as to persons who violate the accident report provision from a first-degree misdemeanor to a third degree felony.

Grand Jury Investigation

The Grand Jury investigation revealed that individuals called "runners" collect accident reports, which are public records, from law enforcement agencies and use the information to solicit persons involved in accidents or give the information to another person who solicits the victims. Other runners, according to the Grand Jury, print the information in "accident journals" sold to medical providers and attorneys who solicit persons involved in accidents.

Once the runner solicits the accident victim, the victim is sent to an unscrupulous medical person who provides a variety of diagnostic tests, characterized by the Grand Jury as "extremely profitable tests of marginal utility or validity," such as nerve conduction studies or video fluoroscopy. The Grand Jury found that "because there is no fee schedule set by the government in PIP claims, and because of the strict rules regarding PIP claims, insurance companies must pay almost any amount billed."

The brokering of certain medical tests also concerned the Grand Jury because individuals have formed magnetic resonance imaging (MRI) brokerage businesses, which negotiate deals with MRI facilities to perform MRI tests and then bill out these same tests to an insurance company for more than the test actually costs. These MRI brokers, according to the Grand Jury, provide no real service other than scheduling an appointment for the accident victim, yet charge that insurance company as if the broker is the actual facility administering the MRI exam. A recent article in the New York Times echoed this problem stating that such "imaging brokers" were behind a "growing number of abusive and often fraudulent charges in the treatment of auto accident victims in Florida."[3] Further, such practices were "a major reason injury claims in several states are rising at three times the rate of medical costs in general."

Personal injury protection claims must be paid within 30 days or the claim is considered overdue and the insurer will be liable in a suit to recover these personal injury protection benefits. The insurer will also be responsible for paying a plaintiff's legal fees, which can add thousands to the amount of the settlement, according to the Grand Jury. The Grand Jury stated that, "doctors and chiropractors who engage in patient brokering and solicitation generally have relationships with one or more lawyers who file suit on the 31st day, if the claim is not paid." Further, "unethical lawyers will often refer clients to a doctor or chiropractor they know will make a finding that their client has been permanently injured. Such a finding is crucial under Florida law because it allows the insured to sue for pain and suffering and thereby recover much more money than simply reimbursement for medical treatment."

In conclusion, the Grand Jury stated that the Legislature, the Department of Insurance, the medical boards, the Florida Bar, the insurance industry, law enforcement and prosecutors must work together to find innovative solutions. In addition, the Grand Jury made further findings and

[3] New York Times, March 22, 2001.

recommendations as to professional discipline for licensed medical professionals and attorneys, which are not addressed in this bill.[4]

B. Florida's No-Fault Law

Background

The Legislature enacted Florida's "no-fault" insurance provisions in 1971. Under the Florida Motor Vehicle No-Fault law, motor vehicle owners are required to maintain $10,000 of personal injury protection (PIP) coverage (ss. 627.730-627.7405, F.S.). Personal injury protection covers the vehicle owner, relatives residing in the same household, passengers or pedestrians involved in the motor vehicle accident who do not have their own personal injury protection coverage, and persons driving the vehicle with the owner's permission. Pursuant to s. 324.022, F.S., vehicle owners must also maintain $10,000 in property damage liability insurance.

Those with PIP coverage receive limited immunity from tort liability for damages to the extent the economic loss is compensated under their personal injury protection policy. This limited immunity protects against non-economic damages, such as pain and suffering, however, the immunity does not extend to injuries consisting of: (1) significant and permanent loss of an important bodily function; (2) permanent injury within a reasonable degree of medical probability (other than scarring or disfigurement); (3) significant and permanent scarring or disfigurement; or (4) death. In short, a plaintiff must suffer a permanent injury in order to seek pain and suffering damages against a motorist with personal injury protection coverage.

Benefits Available

With respect to injuries sustained in a motor vehicle accident, regardless of who is at fault, a vehicle owner's PIP coverage will generally pay 80 percent of medical costs, and 60 percent of lost wages and similar costs, up to a limit of $10,000. Personal injury protection insurance also will pay up to a $5,000 death benefit.

Payment of Claims

To receive payment, health care providers are required to submit medical bills directly to insurers within 30 days of the date of treatment (s. 627.736(5), F.S.). If the medical provider notifies the insurer within 21 days after the first examination or treatment, the provider may submit medical bills within 60 days of the date of treatment. Neither the insurer nor the injured person is required to pay medical bills that are not submitted within this time frame and any agreement to the contrary is unenforceable. Exceptions to this requirement are provided for medical services billed by a hospital for services rendered at a hospital-owned facility, for emergency services rendered by a hospital emergency department, or transport and treatment rendered by an ambulance provider.

[4] Under the rules of the Florida Bar, attorneys are prohibited from soliciting clients "when a significant motive for the lawyer's doing so is the lawyer's pecuniary gain." Further, attorneys are prohibited from making written solicitations of accident and natural disaster victims concerning claims for personal injury or wrongful death within 30 days of the accident or natural disaster. See Rule 4-7.4, Rules Regulating the Florida Bar.

Overdue Payment of Benefits

Personal injury protection benefits are considered overdue if not paid by the insurer within 30 days after the insurer is billed for such charges (s. 627.736(4), F.S). A PIP insurer may refuse to pay for treatment if the insurer has "reasonable proof to establish" that it is not responsible for the payment. Additionally, the 30-day payment requirement may be tolled if the insurer requests medical records within 20 days of receipt of the medical bills in issue and the provider fails to timely furnish such records (s. 627.736(6), F.S.). Upon receiving the requested records, the insurer must provide payment within 10 days. The 30-day payment mandate may also be tolled if the insurer is not furnished statements or bills for medical services, which do not utilize proper medical forms and codes (s. 627.736(5), F.S.).

However, two recent court decisions by the Third District Court of Appeals (*Perez vs. State Farm*, 746 So.2d 1123 (Fla. 3rd DCA 1999) and *United Automobile Ins. Co. vs.. Viles,* 726 So. 2d 320 (Fla. 3rd DCA 1998)) have eroded an insurer's ability to contest certain claims. In *Perez,* the Court held that the insurance company was required to obtain, within 30 days, medical reports providing reasonable proof that it was not responsible for payment. The insurer had argued that the medical treatment was not related, reasonable, or necessary and that the failure to obtain the report did not compel payment of the bills, but only subjected it to paying interest and attorney's fees should liability be established. The Court countered that the insurer lost its right to even contest the claim and thus had to pay the claim, plus interest. Similarly, in *Viles,* the Court held that an insurer could not terminate an insured's PIP benefits without a report by a physician, and thus the insurer was liable for all bills.

Further, a sister appellate court commented on the broad scope of the PIP law in *Palma v. State Farm,* 489 So.2d 147 (Fla. 3rd DCS 1986), when it stated that the broad scope of the no-fault law is highlighted by the inclusion of benefits for remedial treatment and services for an "injured person who relies upon spiritual means through prayer alone for healing in accordance with his religious beliefs."

Currently, an insurer is required to pay simple interest of 10 percent on any overdue claim. A person filing a suit against an insurer for an overdue claim is not required to notify the insurer of the overdue claim before filing suit. If the insurer does not prevail in the case of an overdue claim, the insurer can be liable for the amount of the claim, interest on the overdue claim, and the claimant's attorney's fees (s. 624.155, F.S., and s. 627.428, F.S.). Insurance companies are further in violation of the Insurance Code if they fail to timely provide benefits with such frequency as to constitute a general business practice (s. 627.736(4), F.S.).

Charges for Treatment

Physicians, hospitals, clinics, or other persons may charge only a "reasonable amount" for products, services, and accommodations rendered (s. 627.736(5), F.S.). Physicians, hospitals, clinics, or other persons may not charge more than they customarily charge a person lacking insurance. Only charges for thermograms are limited to the maximum reimbursement allowance set forth for workers' compensation.

The federal Medicare program utilizes a fee schedule, limiting the maximum allowable reimbursement for specified services. Medicare Part B generally covers doctor's bills, outpatient hospital care, and some preventive care. According to the Department of Insurance, a magnetic resonance imaging test of an arm would be reimbursed $604 under the workers' compensation fee schedule set forth in s. 440.13, F.S., and an average of $966 under Medicare Part B.

Independent Medical Examinations

An insurance company may refuse to pay for treatment of a PIP insured when the treatment is not reasonable, not related to the covered motor vehicle accident, or not necessary (s. 627.736(7), F.S.). Such a determination is generally based on a medical examination conducted by a physician selected by the insurer, known as an independent medical examination (IME). The insurance company must pay for the IME. Further, an insurer may not withdraw payment of a treating physician without the consent of the injured person, unless the insurer first obtains a report by a physician licensed under the same chapter as the treating physician, whose treatment authorization is sought to be withdrawn, stating that the treatment was not reasonable, related, or necessary. Attorney's who represent PIP insured's complain about the practice of insurers who utilize what are termed "paper IME's" in which the insurer's physician merely reviews the medical treatment documents of the injured person and then writes a report stating that such medical treatment was not reasonable, related or necessary.

Division of Insurance Fraud (Department of Insurance)

According to the Division of Insurance Fraud, the National Coalition Against Insurance Fraud estimated fraud in Florida's automobile insurance line to be $1.1 billion in 1997, the most recent year for which information was available. During the past 5 years, a total of 5,576 personal injury protection-related referrals involving suspected or actual fraud were reviewed by the division, and 1,218 criminal investigations resulted from the review of referrals. The division made 643 arrests for personal injury protection-related fraud cases, and 416 convictions were obtained based on these arrests. The division employs certified law enforcement officers as investigators with the right to make arrests and bear arms, and it is empowered to investigate all violations of the Insurance Code and related criminal statutes.

Insurance Company Anti-fraud Units

Beginning in 1996, insurance companies authorized to do business in Florida have been required to establish and maintain a division or unit to investigate insurance fraud or adopt an anti-fraud plan, depending on the amount of premium written by the insurer (s. 626.9891, F.S.; ch 95-340, Laws of Florida). Each insurer's anti-fraud plan is required to include a description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts; procedures for the mandatory reporting of possible fraudulent insurance acts to the Department of Insurance; a plan for anti-fraud education and training of its claims adjusters or other personnel; and an organizational arrangement of the anti-fraud personnel responsible for the investigation and reporting of possible fraudulent insurance acts.

Current Penalties for Fraud, Solicitation, Kickbacks, and Patient Brokering

Florida law prohibits insurance fraud (s. 817.234, F.S.), kickbacks (s. 456.065, F.S.), patient brokering (s. 817.505, F.S.), and solicitation (s. 817.234, F.S). Subsection (8) of s. 817.234, F.S., prohibits anyone from soliciting business for the purpose of making motor vehicle tort claims or personal injury protection benefit claims. Subsection (9) similarly prohibits attorneys from soliciting persons injured in motor vehicle accidents for the purpose of making motor vehicle tort claims or personal injury protection benefit claims. A solicitation prohibited by s. 817.234 (8) and (9), F.S., is a third degree felony. The Florida Bar also regulates advertisements and solicitations by attorneys.

C. Licensing And Regulation Of Health Care Professions And Facilities

Health Care Professions

Chapter 456, F.S, sets forth the general provisions for licensure and discipline of health professions and occupations. This chapter also provides for the organization of the various practice boards and further describes the penalties for certain violations. In addition to ch. 456, F.S., four physician groups are regulated under separate provisions of law. These chapters are:

- Chapter 458, regulating medical doctors and establishing the Board of Medicine;
- Chapter 459, regulating osteopathic physicians and establishing the Board of Osteopathic Medicine;
- Chapter 460, regulating chiropractic physicians and establishing the Board of Chiropractic Medicine; and
- Chapter 461, regulating podiatric medicine and establishing the Board of Podiatric Medicine.

Health Care Facilities

Not all health care facilities are required to be licensed or registered by the state. However, certain medical facilities currently are required to be licensed or registered which include abortion clinics, hospitals, ambulatory surgical centers, optometrists' offices, mental health facilities, pharmacies, dental clinics, electrolysis facilities, and massage facilities.

III. Effect of Proposed Changes:

Section 1. Makes legislative findings. It declares that the purpose of the Florida Motor Vehicle No-Fault law includes providing the public affordable PIP insurance intended to provide appropriate medical care quickly, without undue litigation, but that these purposes have been impeded by fraud, medically inappropriate over-utilization of treatment and diagnostic services, inflated charges and other practices by a small number of unscrupulous providers, entrepreneurs and attorneys. It adopts the findings of the Statewide Grand Jury Report on PIP insurance fraud and further finds that the problems addressed in the report are matters of great public interest and importance and that the provisions in the bill are the least-restrictive means by which to solve these problems.

Section 2. Creates s. 456.0375, F.S., effective October 1, 2001, and defines the term "clinic" to mean a business operating in a single structure or facility or group of adjacent structures or facilities under the same business name or management at which health care services are provided and for which such business tenders charges for reimbursement for such services. Such a clinic must register with the Department of Health (DOH), unless the business is:

1. Otherwise licensed, registered, or certified under chapters 390 (abortion), 394 (mental health), 395 (hospitals), 400 (nursing homes), 463 (optometry), 465 (pharmacy), 466 (dental), 478 (electrolysis), 480 (massage), or 484 (optical), or is exempt from federal taxation under the Tax Code; or

2. A group practice, partnership, or corporation that provides health care services by licensed health care practitioners in accordance with chs. 457, 462, 463, 466, 467, 484, 486, 490, 491, F.S., or Parts I, III, X, XIII, or XIV of ch. 468, F.S., which is wholly owned by licensed health care practitioners or the spouse, parent, or child of a licensed health care practitioner.

A clinic in which an entity or individual possesses an ownership interest, other than a physician licensed under chs. 458, 459, 460, or 461, F.S., and each clinic location, must register with the Department of Health. These clinics also would be required to employ or contract with a physician to be medical director. Clinics owned jointly by physicians and their spouses, parents, or children, would not be required to register as long as the physician supervises the services performed at the clinic and is legally responsible.

Registration--Registration requirements would include filing a registration form, which would include the name of the medical director, with the Department of Health and displaying a registration certificate within the clinic. Registration fees would cover the cost of registration and could not exceed the cost to administer and enforce compliance. Registration would be required to be renewed biennially.

Medical Director--Clinics not owned by licensed physicians would be required to hire a physician with a full and unencumbered license as medical director. Responsibilities of the medical director would include having signs identifying the medical director posted in the clinic which are readily visible to all patients; ensuring all practitioners maintain a current active and unencumbered Florida license; reviewing any patient referral contracts or agreements executed by the clinic; ensuring all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided; serving as the clinic records owner as defined under s. 456.057, F.S.; complying with medical record keeping, office surgery, and adverse incident reporting requirements; and conducting systematic reviews of clinic billings to ensure billings are not fraudulent or unlawful. Provides that contracts entered into or renewed by a physician in violation of this section are void.

Rulemaking Authority--The Department of Health would be authorized to adopt rules necessary to implement the registration program, including limitations on the number of clinics that may be supervised by a single medical director.

Violations--Any person establishing, operating, or managing an unregistered clinic would commit a third degree felony and registered clinics could have their registration revoked if found

to be in violation of this section. Also, a violation of the section by a licensed health care practitioner would be grounds for discipline. Any claims made by or on behalf of unregistered clinics would be considered to be unlawful charges and therefore be noncompensable and unenforceable.

Section 3. Amends s. 626.989(4)(c), F.S., to expand the provision of immunity from civil liability for individuals as well as local, state, or federal enforcement officials or their agents or employees, reporting suspected insurance fraud pertaining to parties, in addition to acts, to the Department of Insurance.

Section 4. Amends s. 627.732, F.S., to include a definition of "broker" and "medically necessary" for the purposes of the no-fault law. "Broker" means any person, not possessing a medical license, who charges or receives compensation for use of medical equipment and is not the 100 percent owner or 100 percent lessee of such equipment. A lessee means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. A broker does not include a hospital, physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, an entity that has contracted with the insurer to obtain a discounted rate for such services, or a management company that has contracted to provide management services for a licensed physician whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100 percent owned by one or more hospitals or physicians. Section 5 of the legislation provides that an insurer would not be required to pay a claim made by a broker or by a person making a claim on behalf of a broker.

"Medically necessary" is defined as a medical service or supply a prudent physician would provide for the purposes of treating an illness in a manner that is generally accepted, appropriate, and not for the convenience of the patient or physician.

Section 5. Amends s. 627.736, F.S., to make a number of changes to the personal injury protection statute:

Benefits--The types of medical benefits available under personal injury protection coverage would be amended from "necessary" benefits to "medically necessary" benefits. The benefit for spiritual healing would be modified to provide that the provision does not affect the determination of what other services or procedures are medically necessary. This provision addresses a statement by the 4th District Court in the *Palma* case. (See above under Present Situation Section.)

Payment of Claims—As previously noted, PIP insurance benefits paid pursuant to s. 627.736, F.S., are overdue if not paid with 30 days after the insurer is furnished written notice of the fact of the covered loss and the amount of such loss. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer.

This provision is amended to provide that when an insurer pays only a portion of a claim or rejects a claim, the insurer is required to include with the partial payment or rejection an itemized specification of each item that the insurer has reduced, omitted, or declined to pay, and any

information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the insurer's evidence at trail; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

Further, the personal injury insurer would be allowed an additional 30 days from the date the claim becomes overdue to refer the claim for investigation to the Department of Insurance (Fraud Division) under s. 626.989, F.S.[5] Such referral must be made to the department within 30 days from the "date of the claim" pursuant to s. 626.989, F.S., if the insurer has reasonable evidence to establish that the claim arises from a fraudulent insurance act as defined in s. 626.989, F.S., or is a criminal act involving insurance fraud, including a violation of s. 817.234, F.S., or s. 817.505, F.S., or kick backs under s. 456.054, F.S., associated with a claim for PIP benefits in accordance with s. 627.736, F.S. (This requirement does not change the standard in s. 626.989, F.S., which requires an insurer to refer suspected fraudulent insurance acts or other suspected acts or practice to the Department of Insurance.)

Further, any insurer who engages in a "general business practice" of referring valid claims or portions thereof for investigation to the department commits an unfair trade practice under the Insurance Code. Although this sanction provision is somewhat unclear, it would appear to apply to the unfair methods of competition and unfair or deceptive practices provisions under Part IX of the Insurance Code (s. 626.951-626.99, F.S.). That section subjects insurance companies to a variety of sanctions ranging from penalties and fines to suspension or revocation of an insurer's certificate of authority.

The expiration of the time period for payment of PIP benefits by an insurer would not preclude an insurer from challenging a claim as unrelated, not medically necessary, unreasonable, or that the amount of the charge was in excess or violation of subsection (5)[6]. Further, such challenge could be made at any time, including after payment of the claim or after the 30-day time period. This provision nullifies the *Perez* decision because it allows an insurer to contest claims after the 30-day time period expires (See discussion of *Perez* under Present Situation, above.)

Overdue Claims-- An insurer would be required to pay simple interest as indexed in s. 55.03, F.S., or the amount in the insurance contract, whichever is greater, rather than a constant rate of 10 percent which is current law. Under s. 55.03, F.S., the Comptroller is required, on December 1 of each year, to set the rate of interest payable on judgments and decrees for the year beginning the following January 1. The Comptroller sets the rate by averaging the discount rate of the Federal Reserve Bank of New York for the preceding year, then adding 500 basis points to the averaged federal discount rate. Additionally, interest would be calculated from the date the insurer was first provided written notice of the amount of covered loss. (The interest rate calculated under s. 55.03, F.S., for the year 2001 is 11 percent.)

[5] That subsection specifies what persons or entities must make referrals to the Fraud Division; provides for investigation of the referral; and provides what investigations are to be referred for prosecution.
[6] s. 627.736(5), F.S., refers to charges for the treatment of injured persons under PIP.

Medical Payments--Removes this provision of law, which currently requires that medical payment insurance pay for the 20 percent of medical benefits not paid under PIP.

Prohibited Charges by Brokers -- Provides that an insurer would not be required to pay a claim made by a broker or by a person making a claim on behalf of a broker. This provision essentially would outlaw broker activity which was described in the Grand Jury Report.

Fee Schedule--Five additional diagnostic tests would be subjected to the fee schedule under the workers' compensation statute (s. 440.13, F.S.), which is presently applicable only to thermograms. These five tests are: spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing.

Charges for magnetic resonance imaging (MRIs) services would be limited to 75 percent of the Ingenix Customized Fee Analyzer for the zip code prefix "330" for the year 2000 plus annual increases equal to the medical consumer price index for Florida. (Ingenix, a large health data and information company, provides a service which takes actual charge data for a physician's specific geographic location and specialty and publishes such data in an annual report.) Hospitals and those medical facilities licensed under ch. 395, F.S., would not be subject to the MRI fee schedule.

Provider Billing Requirements--Clarifies that medical treatments or services billed by a hospital or other provider for emergency services rendered at a hospital-owned facility are not subject to the 30-day provider billing requirement. The legislation would increase the current 30-day billing requirement to 35 days for providers to bill insurance companies, and increase the current 60-day provision to 75 days. This would mean that if a provider notified the insurer of initiation of medical treatment of a PIP insured within 21 days after the first treatment, the provider could then have 75 days in which to submit the statement of charges to the insurer. The legislation would further allow the provider more time to submit bills to insurers if such provider was given incorrect insurer information by the insured. Specifically, if the insured failed to give the provider the correct name and address of the insured's PIP insurer, the provider would have 35 days from the date the provider obtains the correct information to furnish the insurance company with a statement of charges. However, the insurer is not required to pay the charges unless the provider includes with the statement evidence documenting that the provider relied on erroneous information from the insured, and either a denial letter from the incorrect insurance company, or proof of mailing, which may include an affidavit under penalty of perjury reflecting the timely mailing to the incorrect address or insurer.

Independent Medical Examinations (IMEs)--Under current law, a PIP insurance company can not withdraw payment of a treating physician without the consent of the injured person, unless the company first obtains a "report" by another physician stating that such treatment was not reasonable, related, or necessary (see discussion above under Present Situation). The legislation requires that such a report be a "valid" one and specifies what a valid report means. It provides that such a report is one prepared and signed by the physician examining the injured person or, in the alternative, reviewing the treatment records of the injured person and such report is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. It further provides that the physician preparing the report must be in active practice (unless such physician is physically disabled) which means that during

the 3 years preceding the date of the physical exam or review of the records, the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions, or the instruction of students in specified accredited health, residency or clinical programs.

The effect of this provision is to help remedy the current practice of PIP insurers utilizing what are termed "paper IME's" in which the insurer's physician merely reviews the medical treatment documents of the injured person and writes a report stating that such treatment was not reasonable, related or necessary.

Reporting Requirements--Electronic access to vehicle insurer information maintained by the Department of Highway Safety and Motor Vehicles may be provided by a third-party provider to insurers, lawyers and financial institutions for subrogation and claims purposes only. The compilation of and retention of this information is prohibited.

Pre-suit Notice ("Demand Letter")--Provides that a written notice of intent to initiate litigation must be provided to the insurer as a condition precedent to filing suit for an overdue claim, but such notice would apply only to claims that are not overdue and not more than 45 days after the insurer's receipt of written notice of the fact of a covered loss and of the amount of such loss.

The pre-suit notice could not be sent until the claim is overdue (as previously described) and must state with specificity certain information to be included in the notice, including the name of the medical provider who rendered treatment or supplies to the insured be provided along with an itemized statement listing the exact amount, dates of treatment, service and type of benefits claimed to be due. Such notice must be sent to the insurer at the address to which the claim in issue was sent or current address, if known, and to the adjuster handling the claim, if known. If the claim, along with applicable interest, is paid within 7 business days, the claimant would be prohibited from bringing an action against the insurer for nonpayment or late payment of a claim. The statute of limitations would be tolled for a period of 15 days by the mailing of the notice. The legislation further provides that any insurer who engages in a general business practice of taking no action to pay, deny, or reduce valid claims or portions thereof until receipt of the notice, commits an unfair trade practice under the Insurance Code.

Civil Action--A civil cause of action would be created for insurers against a person found guilty of or who pleads guilty or nolo contendere to, regardless of adjudication of guilt, to insurance fraud, patient brokering, or kickbacks. Insurers prevailing under this section could recover compensatory, consequential, and punitive damages and attorney's fees.

Section 6. Amends s. 627.739, F.S., relating to PIP, to provide that no insurer is required to pay any charge as to which the provider has failed to bill a co-payment or deductible; except that this provision does not apply where a provider has waived a co-payment or deductible in individual infrequent cases, not as a general business practice, related to a specific patient's ability to pay.

Section 7. Amends s. 817.234(8)(9)(11), F.S., relating to false or fraudulent insurance claims to specify that it is unlawful for any person to solicit or cause to be solicited a person involved in a motor vehicle crash by any means of communication, other than advertising directed to the

general public. Charges for services rendered by a health care provider or attorney who violated this provision in regard to the person for whom such services were rendered would be considered an unlawful charge and would be unenforceable. It provides for a minimum mandatory sentence of 6 months imprisonment for persons convicted of violating this subsection. It further provides for minimum mandatory sentences ranging from 6 months to 2 years imprisonment depending on the value of the property involved in the insurance fraud.

If a court imposes only the 6-month minimum mandatory term prescribed in this section, the sentence would be served in county jail because a state prison sentence must exceed 1 year imprisonment. s. 921.0024(2), F.S.

Section 8. Amends s. 817.505, F.S., relating to patient brokering, to provide that a person convicted of patient brokering shall be sentenced to 6 months imprisonment.

If a court imposes only the 6-month minimum mandatory term prescribed in this section, the sentence would be served in county jail because a state prison sentence must exceed 1 year imprisonment. s. 921.0024(2), F.S.

Section 9. Amends s. 324.021, F.S., to correct a cross-reference in the statutes as to the definition of "motor vehicle."

Section 10. Provides that, except as otherwise expressly provided in the legislation, the legislation takes effect upon becoming a law.

Paragraph (1)(a), (4)(c), (7)(a), and sub-paragraph (4)(b)1. of s. 627.736, F.S., as amended by section 5 of CS/CS/SB 1092, the deletion of (4)(f) and relettering of paragraph (4)(g) to (4)(f), as amended by section 5, apply to policies issued new or renewed on or after October 1, 2001.

Paragraphs (5)(b) and (5)(c) of s. 627.736, F.S., as amended by section 5, and subsection (6) of s. 627.739, F.S., as added by section 6, apply to treatment and services occurring on and after October 1, 2001.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Any reduction in insurance fraud resulting from this legislation should reduce insurer loss experience and could result in premium savings for policyholders. Medical providers may experience a greater delay in receiving reimbursement or lower reimbursement for PIP claims. However, medical providers will benefit by having more time to send their statements of charges to insurers.

Clinics subject to the registration requirement will incur costs associated with registration and employment of a medical director. Registration costs as to each clinic will be determined by rule of the Department of Health.

Persons involved in brokering will not be compensated by insurers, unless such persons come under the brokering exceptions provided for in this bill. Certain entities providing magnetic resonance imaging (MRI) services will be limited to recovery of a maximum reimbursement rate based on the ingenex fee analyzer. The impact on these entities depends on the degree to which the amount they charge for these services exceeds the proposed maximum rate. Those entities providing certain other diagnostic tests specified in the bill will be subject to the fee schedule set for workers' compensation claims. Again, the extent of financial impact depends on the degree to which the amount they charge for these services exceeds the proposed maximum rate.

Injured insureds may benefit because insurance companies may not discontinue treatment by the insured's physician unless such companies obtain valid reports from physicians as specified in the legislation.

C. Government Sector Impact:

CS/CS/SB 1092 requires the registration of certain clinics and allows the Department of Health to collect a registration fee. The department will establish the registration fee by rule and the fee must reasonably cover the costs of registration and enforcement actvities. Clinics are required to renew their registration biennially.

The bill takes effect on October 1, 2001, and provides that all clinics must file registration forms within 60 days after the effective date of the law (November 30, 2001), or prior to the inception of operation.

The Department of Health does not have data regarding the number of health care clinics operating in Florida. Due to the absence of reliable data, the department based its fiscal impact on the assumption that there would be 1,000 clinics that would register in the first year of implementation, FY 01-02. The fiscal analysis also assumes a 10 percent growth of 100 new clinics in the second year.

There would be a one-time, non-recurring workload to develop the program, including specifications for data system modifications, distribution of information to licensees regarding the new registration requirements, and coordination with the Agency for Health Care Administration (AHCA) regarding cross-checking of AHCA data about clinics that may already be licensed by AHCA and exempt from registration requirements. This workload will require OPS funding for program development activities, and expense funding of $35,000 to cover expenses relating to printing and postage for mailout of information to approximately 50,000 licensed physicians regarding the new registration requirements.

The Department maintains a database of application and licensing data on all regulated professions. Modifications to this computer system to add this new program would be accomplished by the Department's Information Technology staff and would be accomplished within existing resources.

Based on the minimal registration requirements in the bill, the registration process will likewise be very streamlined. This registration program would be designed to utilize the Department's current public/private model of application processing and issuance of licenses. The Department's contract with a private business entity would be expanded to add this new program. The private contractor would receive the registration forms, process the forms, and issue the registration certificate. The current unit price for this application processing is $6.98 per application, and the unit price for issuing a certificate is $1.45, for a total of $8.43 per application and registration. Estimating 1,000 applications in FY 01-02, the contractor's charges would be 1,000 times $8.43 for a total of $8,430. The contractor would also likely charge an estimated $1,500 for one-time computer software program modifications to accommodate this new program.

During the first year, the Department will utilize the Department's website to publicize and provide information about registration requirements, and to provide registration applications for applicants to download and print, thus avoiding delays in requesting applications by mail. E-mail will also be utilized as extensively as possible for communication regarding registration questions. Given the minimal statutory registration requirements, applications that are submitted with complete information should not require the full 30 days provided by Chapter 120, F. S., for processing. It is anticipated that upon receipt of a complete application, a registration certificate should be returned to the applicant within a number of days.

The Department has recently successfully implemented internet based credit card transactions for renewal of nursing licenses. However, given the lack of information with which to reliably estimate the volume of clinics that will be required to register under this new program, the Department is unable at this time to complete an analysis of the feasibility and cost-effectiveness of developing an internet based registration transaction system for this new registration program. In addition to information about the volume of clinics, other data system issues will require examination and analysis, including data security issues and data exchange with the AHCA regarding applicant licensure under other programs. It is expected that after the first year's experience, the Department will have volume data and

other information necessary to complete a feasibility analysis and proposal for an internet based credit-card application transaction system for initial applications as well as registration renewals.

The Department will require ½ of a Regulatory Specialist position to handle the ongoing operational responsibilities of this program, e.g., responding to inquiries, processing incomplete applications that are returned to the Department by the contractor, and monitoring and reporting on issues related to the implementation and management of the program. First year funding for the ½ FTE is needed for a full 12 months, to ensure that the staff person is hired and trained prior to the October 1, 2001 implementation date. The Department will also require initial OPS funding for program development and implementation activities, 12 weeks times 40 hours per week times $10 per hour.

The bill provides that registration fees shall be reasonably calculated to cover the costs of registration as well as compliance enforcement. Compliance enforcement is handled by the Department through a contract with the ACHA. The Agency conducts investigations of complaints that a regulated licensee is not complying with licensure laws and rules. Enforcement of compliance is accomplished through these complaint investigations and subsequent penalties for violations. Historically, complaint data indicates that complaints are received regarding approximately three to five percent of licensees annually. Based on an assumption of 1,000 licensees, it is assumed that the AHCA will receive and investigate approximately 30 to 50 complaints annually. An estimate of investigation and prosecution costs for this new program will be included in the AHCA analysis of this bill. For purposes of this department analysis, it is assumed that the AHCA will require $15,000 the first year, and $50,000 annually thereafter in appropriated spending authority to cover the costs of enforcement compliance activities.

Based on this estimate of registration and enforcement costs, and on the variation in revenue in alternate years, the registration fee would need to be set at $150 to ensure sufficient cash to support enforcement activities in the alternate year of reduced revenue from fluctuating volume of registration renewal revenue.

Although the bill provides authority to collect registration fees sufficient to cover the costs of registration and enforcement, the bill does not include an appropriation to the Department to provide spending authority for the revenue. An appropriation will be necessary to implement the program.The Department of Health projects that revenue collections will be sufficient to cover the costs of the program in FY 01-02.

The Criminal Justice Estimating Conference reviewed the criminal penalty provisions of CS/SB 1092 and determined that the bill will have an insignificant impact on the state's prison population. To the extent that offenders are sentenced to six months imprisonment, the bill will have an impact on county jail populations.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Appropriations Subcommittee on Public Safety and Judiciary – removes the mandatory minimum terms of imprisonment and specifically ranks certain criminal offenses for purposes of sentencing under the Criminal Punishment Code, as follows:

Level 3:

ss. 817.234(8) & (9), F.S.	3rd degree felony	Unlawful solicitation of persons involved in motor vehicle accidents.
s. 817.234(11)(a), F.S.	3rd degree felony	Insurance fraud; property value less than $20,000.
s. 817.505(4), F.S.	3rd degree felony	Patient brokering.

Level 5:

s. 817.234(11)(b), F.S.	2nd degree felony	Insurance fraud; property value $20,000 or more but less than $100,000.

Level 7:

s. 817.234(11)(c), F.S.	1st degree felony	Insurance fraud; property value $100,000 or more.