CHAMBER ACTION

Senate		House
	.	
	.	
	.	

---

1 Representative Brown offered the following:

2

3 **Amendment (with title amendment)**

4 On page 91, after line 31, insert:

5 Section 81. Paragraphs (b) and (e) of subsection (5) of
6 section 627.736, Florida Statutes, are amended to read:

7 627.736 Required personal injury protection benefits;
8 exclusions; priority; claims.--

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

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

12 a. Made by a broker or by a person making a claim on
13 behalf of a broker;

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

16 c. To any person who knowingly submits a false or
17 misleading statement relating to the claim or charges;
18 d. With respect to a bill or statement that does not
19 substantially meet the applicable requirements of paragraph (d);
20 e. For any treatment or service that is upcoded, or that
21 is unbundled when such treatment or services should be bundled,
22 in accordance with paragraph(d). To facilitate prompt payment of
23 lawful services, an insurer may change codes that it determines
24 to have been improperly or incorrectly upcoded or unbundled, and
25 may make payment based on the changed codes, without affecting
26 the right of the provider to dispute the change by the insurer,
27 provided that before doing so, the insurer must contact the
28 health care provider and discuss the reasons for the insurer's
29 change and the health care provider's reason for the coding, or
30 make a reasonable good faith effort to do so, as documented in
31 the insurer's file; and
32 f. For medical services or treatment billed by a physician
33 and not provided in a hospital unless such services are rendered
34 by the physician or are incident to his or her professional
35 services and are included on the physician's bill, including
36 documentation verifying that the physician is responsible for
37 the medical services that were rendered and billed.
38 2. Charges for medically necessary cephalic thermograms,
39 peripheral thermograms, spinal ultrasounds, extremity
40 ultrasounds, video fluoroscopy, and surface electromyography
41 shall not exceed the maximum reimbursement allowance for such
42 procedures as set forth in the applicable fee schedule or other
43 payment methodology established pursuant to s. 440.13.

44 3. Allowable amounts that may be charged to a personal
45 injury protection insurance insurer and insured for medically
46 necessary nerve conduction testing when done in conjunction with
47 a needle electromyography procedure and both are performed and
48 billed solely by a physician licensed under chapter 458, chapter
49 459, chapter 460, or chapter 461 who is also certified by the
50 American Board of Electrodiagnostic Medicine or by a board
51 recognized by the American Board of Medical Specialties or the
52 American Osteopathic Association or who holds diplomate status
53 with the American Chiropractic Neurology Board or its
54 predecessors shall not exceed 200 percent of the allowable
55 amount under the participating physician fee schedule of
56 Medicare Part B for year 2001, for the area in which the
57 treatment was rendered, adjusted annually on August 1 to reflect
58 the prior calendar year's changes in the annual Medical Care
59 Item of the Consumer Price Index for All Urban Consumers in the
60 South Region as determined by the Bureau of Labor Statistics of
61 the United States Department of Labor.
62 4. Allowable amounts that may be charged to a personal
63 injury protection insurance insurer and insured for medically
64 necessary nerve conduction testing that does not meet the
65 requirements of subparagraph 3. shall not exceed the applicable
66 fee schedule or other payment methodology established pursuant
67 to s. 440.13.
68 5. Effective upon this act becoming a law and before
69 November 1, 2001, allowable amounts that may be charged to a
70 personal injury protection insurance insurer and insured for
71 magnetic resonance imaging services shall not exceed 200 percent

72 of the allowable amount under Medicare Part B for year 2001, for
73 the area in which the treatment was rendered. Beginning November
74 1, 2001, allowable amounts that may be charged to a personal
75 injury protection insurance insurer and insured for magnetic
76 resonance imaging services shall not exceed 175 percent of the
77 allowable amount under the participating physician fee schedule
78 of Medicare Part B for year 2001, for the area in which the
79 treatment was rendered, adjusted annually on August 1 to reflect
80 the prior calendar year's changes in the annual Medical Care
81 Item of the Consumer Price Index for All Urban Consumers in the
82 South Region as determined by the Bureau of Labor Statistics of
83 the United States Department of Labor ~~for the 12-month period~~
84 ~~ending June 30 of that year~~, except that allowable amounts that
85 may be charged to a personal injury protection insurance insurer
86 and insured for magnetic resonance imaging services provided in
87 facilities accredited by the Accreditation Association for
88 Ambulatory Health Care, the American College of Radiology, or
89 the Joint Commission on Accreditation of Healthcare
90 Organizations shall not exceed 200 percent of the allowable
91 amount under the participating physician fee schedule of
92 Medicare Part B for year 2001, for the area in which the
93 treatment was rendered, adjusted annually on August 1 to reflect
94 the prior calendar year's changes in the annual Medical Care
95 Item of the Consumer Price Index for All Urban Consumers in the
96 South Region as determined by the Bureau of Labor Statistics of
97 the United States Department of Labor ~~for the 12-month period~~
98 ~~ending June 30 of that year~~. This paragraph does not apply to
99 charges for magnetic resonance imaging services and nerve

100 conduction testing for inpatients and emergency services and
101 care as defined in chapter 395 rendered by facilities licensed
102 under chapter 395.
103 6. The Department of Health, in consultation with the
104 appropriate professional licensing boards, shall adopt, by rule,
105 a list of diagnostic tests deemed not to be medically necessary
106 for use in the treatment of persons sustaining bodily injury
107 covered by personal injury protection benefits under this
108 section. The initial list shall be adopted by January 1, 2004,
109 and shall be revised from time to time as determined by the
110 Department of Health, in consultation with the respective
111 professional licensing boards. Inclusion of a test on the list
112 of invalid diagnostic tests shall be based on lack of
113 demonstrated medical value and a level of general acceptance by
114 the relevant provider community and shall not be dependent for
115 results entirely upon subjective patient response.
116 Notwithstanding its inclusion on a fee schedule in this
117 subsection, an insurer or insured is not required to pay any
118 charges or reimburse claims for any invalid diagnostic test as
119 determined by the Department of Health.
120 (e)1. At the initial treatment or service provided, each
121 physician, other licensed professional, clinic, or other medical
122 institution providing medical services upon which a claim for
123 personal injury protection benefits is based shall require an
124 insured person, or his or her guardian, to execute a disclosure
125 and acknowledgment form, which reflects at a minimum that:

126 a. The insured, or his or her guardian, must countersign
127 the form attesting to the fact that the services set forth
128 therein were actually rendered;
129 b. The insured, or his or her guardian, has both the right
130 and affirmative duty to confirm that the services were actually
131 rendered;
132 c. The insured, or his or her guardian, was not solicited
133 by any person to seek any services from the medical provider;
134 d. That the physician, other licensed professional,
135 clinic, or other medical institution rendering services for
136 which payment is being claimed explained the services to the
137 insured or his or her guardian; and
138 e. If the insured notifies the insurer in writing of a
139 billing error, the insured may be entitled to a certain
140 percentage of a reduction in the amounts paid by the insured's
141 motor vehicle insurer.
142 2. The physician, other licensed professional, clinic, or
143 other medical institution rendering services for which payment
144 is being claimed has the affirmative duty to explain the
145 services rendered to the insured, or his or her guardian, so
146 that the insured, or his or her guardian, countersigns the form
147 with informed consent.
148 3. Countersignature by the insured, or his or her
149 guardian, is not required for the reading of diagnostic tests or
150 other services that are of such a nature that they are not
151 required to be performed in the presence of the insured.

152 4. The licensed medical professional rendering treatment
153 for which payment is being claimed must sign, by his or her own
154 hand, the form complying with this paragraph.
155 5. The original completed disclosure and acknowledgment
156 form shall be furnished to the insurer pursuant to paragraph
157 (4)(b) and may not be electronically furnished.
158 6. This disclosure and acknowledgment form is not required
159 for services billed by a provider for emergency services as
160 defined in s. 395.002, for emergency services and care as
161 defined in s. 395.002 rendered in a hospital emergency
162 department, <u>for services rendered in an ambulatory surgical</u>
163 <u>center as defined in s. 395.002,</u> or for transport and treatment
164 rendered by an ambulance provider licensed pursuant to part III
165 of chapter 401.
166 7. The Financial Services Commission shall adopt, by rule,
167 a standard disclosure and acknowledgment form that shall be used
168 to fulfill the requirements of this paragraph, effective 90 days
169 after such form is adopted and becomes final. The commission
170 shall adopt a proposed rule by October 1, 2003. Until the rule
171 is final, the provider may use a form of its own which otherwise
172 complies with the requirements of this paragraph.
173 8. As used in this paragraph, "countersigned" means a
174 second or verifying signature, as on a previously signed
175 document, and is not satisfied by the statement "signature on
176 file" or any similar statement.
177 9. The requirements of this paragraph apply only with
178 respect to the initial treatment or service of the insured by a
179 provider. For subsequent treatments or service, the provider

180 must maintain a patient log signed by the patient, in
181 chronological order by date of service, that is consistent with
182 the services being rendered to the patient as claimed. The
183 requirements of this subparagraph for maintaining a patient log
184 signed by the patient may be met by a hospital or ambulatory
185 surgical center that maintains medical records as required by s.
186 395.3025 and applicable rules and makes such records available
187 to the insurer upon request.
188
189
190 ================= T I T L E A M E N D M E N T =================
191 On page 4, remove line(s) 24 and insert:
192 Program; amending s. 627.736, F.S.; deleting the period of
193 time relating to adjustments in the Medical Care Item of
194 the Consumer Price Index which applies to allowable
195 amounts that may be charged to a personal injury
196 protection insurance insurer and insured for magnetic
197 resonance imaging services; exempting services rendered by
198 an ambulatory surgical center from certain disclosure
199 requirements; providing that the transfer of the