By Senator Brandes

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A bill to be entitled

An act relating to compensation for personal injury or wrongful death arising from a medical injury; amending s. 456.013, F.S.; requiring the Department of Health or certain boards thereof to require the completion of a course relating to prevention and communication of medical errors as part of the licensure and renewal process; providing a directive to the Division of Law Revision and Information; creating s. 766.401, F.S.; providing a short title; creating s. 766.402, F.S.; defining terms; creating s. 766.403, F.S.; providing legislative findings and intent; specifying that certain provisions are an exclusive remedy for personal injury or wrongful death; providing for early offer of settlement; prohibiting use of the procedures under this act if a claim has already been settled; prohibiting compensation from being awarded if the application is filed by certain persons; creating s. 766.404, F.S.; creating the Patient Compensation System; providing for a Patient Compensation Board; providing for membership, meetings, and certain compensation; providing for specific staff, offices, committees, and panels and the powers and duties thereof; prohibiting certain conflicts of interest; authorizing the board to make rules; creating s. 766.405, F.S.; providing a process for filing applications for compensation under the system; providing for notice to the applicant; providing an application filing period; creating s. 766.406, F.S.;

requiring individuals with relevant clinical expertise to determine whether the facts stated in the application, prima facie, rise to a claim for medical injury; requiring the Office of Medical Review to immediately notify, by registered or certified mail, specified parties under certain circumstances; requiring the notification to inform the provider that he or she may support the application to expedite the processing of the application; providing a timeframe by which a participating provider may support an application; requiring the Office of Medical Review to send a rejection letter in certain circumstances to the applicant by registered or certified mail to inform the applicant of his or her right to appeal; authorizing the applicant to appeal the office's determination; requiring specified individuals to review an application that is supported by a participating provider within a specified timeframe; requiring the Office of Medical Review to determine whether the application is valid; requiring the Office of Medical Review to notify the applicant of a rejection of the application if it finds the application is not valid; requiring the Office of Medical Review to immediately notify relevant law enforcement authorities in the case of fraud; requiring the office to complete a thorough investigation of the application within a specified time period in certain circumstances; requiring the investigation to be conducted in a specified form;

requiring the chief medical officer to allow the applicant and participating provider to access records, statements, and other information in the course of its investigation within a specified timeframe; requiring a chief medical officer to convene an independent medical review panel to make a determination within a specified timeframe; requiring that all information, including information that was previously redacted, be given to the independent medical review panel, and requiring the panel to make a written determination within a specified period; requiring the panel to dismiss an application under certain circumstances; requiring a panel to report that the application supports a claim for medical injury if it determines by the preponderance of the evidence that certain criteria are met; requiring the Office of Medical Review to immediately notify the participating provider by registered or certified mail of the right to appeal the determination of the panel; providing that a participating provider has a specified timeframe within which to appeal the determination of the panel; requiring the Office of Compensation to make a written determination of an award of compensation in certain circumstances; requiring the Office of Compensation to notify the applicant and participating provider by registered or certified mail of the amount of compensation with an explanation of the appeals process; providing that the applicant has a specified time to appeal the award;

requiring compensation for an application to be offset by any past and future collateral source payments; requiring the insurer to remit the compensation award to the Patient Compensation System, which must immediately provide such compensation to the applicant; requiring the payment of specified interest on unpaid awards after a certain date; providing that the findings under this act do not constitute a finding of medical malpractice for purposes of s. 26, Art. X of the State Constitution; requiring the Patient Compensation System to provide the department with electronic access to specified applications if the Patient Compensation Trust Fund determines that the provider presents an imminent risk of harm to the public; requiring the department to review specified applications; creating s. 766.407, F.S.; providing for review of awards by an administrative law judge; providing that a determination by an administrative law judge is conclusive and binding and that a written decision must be provided to the applicant and the participating provider; authorizing an applicant to appeal the award or denial of compensation to the district court of appeal; requiring appeals to be filed under specified rules of procedure; authorizing an administrative law judge to grant an extension upon a written petition by the applicant or the participating provider; creating s. 766.408, F.S.; requiring annual contributions from specified providers to cover administrative expenses; providing

maximum contribution rates; specifying payment dates; providing for disciplinary proceedings for failure to pay; providing for the deposit of funds; authorizing providers to opt out of participation; providing requirements for such an election; creating s. 766.409, F.S.; requiring each participating provider to provide notice to patients of the provider's participation in the Patient Compensation System; creating s. 766.411, F.S.; requiring an annual report to the Governor and the Legislature; providing for retroactive applicability; providing an effective date.

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

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

456.013 Department; general licensing provisions.—

(7) The boards, or the department when there is no board, shall require the completion of a 2-hour course relating to prevention and communication of medical errors as part of the licensure and renewal process. The 2-hour course counts toward ~~shall count towards~~ the total number of continuing education hours required for the profession. The course must ~~shall~~ be approved by the board or department, as appropriate, and must ~~shall~~ include a study of root-cause analysis, error reduction and prevention, ~~and~~ patient safety, and communication of medical errors to patients and their families. In addition, the course approved by the Board of Medicine and the Board of Osteopathic

Medicine must ~~shall~~ include information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the board. If the course is being offered by a facility licensed pursuant to chapter 395 for its employees, the board may approve up to 1 hour of the 2-hour course to be specifically related to error reduction and prevention methods used in that facility.

Section 2. The Division of Law Revision and Information is directed to designate ss. 766.101-766.1185, Florida Statutes, as part I of chapter 766, Florida Statutes, entitled "Medical Malpractice and Related Matters"; ss. 766.201-766.212, Florida Statutes, as part II of that chapter, entitled "Presuit Investigation and Voluntary Binding Arbitration"; ss. 766.301-766.316, Florida Statutes, as part III of that chapter, entitled "Birth-Related Neurological Injuries"; and ss. 766.401-766.412, Florida Statutes, as created by this act, as part IV of that chapter, entitled "Patient Compensation System."

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

766.401 Short title.—This part may be cited as the "Patient Compensation System."

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

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

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

(2) "Application" means a request for investigation by the Patient Compensation System of an alleged occurrence of a

medical injury.

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

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

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

(b) A health, sickness, or income disability insurance; an automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the applicant, whether purchased by the applicant or provided by others.

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

(d) A contractual or voluntary wage continuation plan provided by employers or by a system intended to provide wages during a period of disability.

(5) "Committee" means, as the context requires, the medical review committee or the compensation committee.

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

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

(8) "Independent medical review panel" or "panel" means a multidisciplinary panel convened by the chief medical officer

appointed under s. 766.404(2)(f) to review each application.

(9)(a) "Medical injury" means a personal injury or wrongful death arising out of medical treatment, including a misdiagnosis, which could have been avoided had the care been provided by:

1. An individual participating provider, under the care of an experienced specialist practicing in the same field of care under the same or similar circumstances or, for a general practitioner, an experienced general practitioner practicing under the same or similar circumstances; or

2. A participating provider in a system of care, if the care was rendered within an optimal system of care under the same or similar circumstances.

(b) The term includes the failure to use an alternate course of treatment only if the injury or death could have been avoided through that alternate course of treatment, and that alternate course of treatment is an equally or more effective treatment for the underlying condition. In addition, a medical injury determination must be based on the information that would have been known to an experienced specialist or readily available if an optimal system of care had been available at the time of the medical treatment.

(c) For purposes of this subsection, the term does not include an injury or wrongful death arising out of circumstances in which the medical treatment conformed with national practice standards for the care and treatment of patients as determined by the independent medical review panel.

(d) The term shall be construed to encompass a broader range of personal injuries than are encompassed by a negligence

standard, such that a greater number of applications qualify for compensation under this part than claims filed under a negligence standard.

(10) "Office" means the Office of Compensation, the Office of Medical Review, or the Office of Quality Improvement.

(11) "Panelist" means a person who meets the definition of a provider under this act.

(12) "Participating provider" means a provider that, at the time of the medical injury, had paid the contribution required for participation in the Patient Compensation System for the year in which the medical injury occurred.

(13) "Patient Compensation System" means the organization created in s. 766.404.

(14) "Provider" means:

(a) A birth center licensed under chapter 383;

(b) A facility licensed under chapter 390, chapter 395, or chapter 400;

(c) A home health agency or nurse registry licensed under part III of chapter 400;

(d) A health care services pool registered under part IX of chapter 400;

(e) A person certified under s. 401.27;

(f) A person licensed under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 467, part I, part II, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468, chapter 478, part III of chapter 483, or chapter 486;

(g) A clinical laboratory licensed under part I of chapter

483;

(h) A multiphasic health testing center licensed under part II of chapter 483;

(i) A health maintenance organization authorized under part I of chapter 641;

(j) A blood bank;

(k) A plasma center;

(l) An industrial clinic;

(m) A renal dialysis facility; or

(n) A professional association partnership, corporation, joint venture, or other association pertaining to the professional activity of health care providers.

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

766.403 Legislative findings and intent; exclusive remedy; early offers; wrongful death.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds that:

(a) The lack of legal representation, and, thus, compensation, for the majority of patients with legitimate medical injuries is creating an access-to-courts crisis.

(b) Seeking compensation through medical malpractice litigation is a costly and protracted process. Legal counsel may be able to afford to finance only a small number of legitimate claims.

(c) Even for injured patients who are able to obtain legal representation, the delay in obtaining compensation averages 5 years, imposing a significant hardship on injured patients, who often need access to immediate care and compensation, and their caregivers.

(d) Because of continued exposure to liability, an overwhelming majority of physicians practice defensive medicine by ordering unnecessary tests and procedures, increasing the cost of health care for individuals covered by public and private health insurance and exposing patients to unnecessary clinical risks.

(e) A significant number of physicians, particularly obstetricians, intend to discontinue providing services in Florida as a result of the cost and risk of medical liability in this state.

(f) Recruiting physicians to practice in this state and ensuring that current physicians continue to practice in this state is a public necessity.

(2) LEGISLATIVE INTENT.—The Legislature intends:

(a) To avoid excessive medical malpractice litigation by creating a new remedy through which patients are fairly and expeditiously compensated for medical injuries. As provided in this part, this alternative is intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs; increase patient safety; increase the number of physicians practicing in this state; and provide patients fair and timely compensation without the expense and delay of the court system. The Legislature intends that this part apply to all health care facilities and health care providers who are insured or self-insured against claims for medical malpractice.

(b) That an application filed under this part not constitute a claim for medical malpractice, that any action on such an application not constitute a judgment or adjudication for medical malpractice, and, therefore, that professional

liability insurance companies and self-insured facilities and providers not be obligated to report such applications, or actions on such applications, to the National Practitioner Data Bank.

(c) That, because the Patient Compensation System has the primary duty to determine the validity and compensation of each application, an insurer not be subject to a statutory or common law bad faith cause of action relating to an application filed under this part.

(3) EXCLUSIVE REMEDY.—Except as provided in part III, the rights and remedies granted under this part exclude all other rights and remedies of the applicant and his or her personal representative, parents, dependents, and next of kin, at common law or as provided in general law, against any participating provider directly involved in providing the medical treatment resulting in such injury or death, arising out of or related to a medical negligence claim, whether in tort or in contract, with respect to such injury. Notwithstanding any other law, this part applies exclusively to applications submitted under this part.

(4) EARLY OFFER.—This part does not prohibit a self-insured provider or an insurer from providing an early offer of settlement or apology in satisfaction of a medical injury. A person who accepts a settlement or apology offer may not then file an application under this part for the same medical injury. If an application is filed before an offer of settlement is made, the acceptance of the settlement offer by the applicant results in the withdrawal of the application.

(5) WRONGFUL DEATH.—Compensation may not be provided under this part for an application requesting an investigation of an

alleged wrongful death arising out of medical treatment, if such application is filed by an adult child on behalf of his or her parent or by a parent on behalf of his or her adult child.

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

766.404 Patient Compensation System; board; committees.—

(1) PATIENT COMPENSATION SYSTEM.—The Patient Compensation System is created and administered within the department. The Patient Compensation System is a separate budget entity that is not subject to control, supervision, or direction by the department. The Patient Compensation System administers this part.

(2) PATIENT COMPENSATION BOARD.—The Patient Compensation Board is a board of trustees as defined in s. 20.03(12) and is established to govern the Patient Compensation System. The board must comply with the requirements of s. 20.052, except as provided in this subsection.

(a) *Members.*—The board consists of 11 members who represent the medical, legal, patient, and business communities from diverse geographic areas throughout the state. Members of the board serve at the pleasure of the Governor and are appointed by the Governor as follows:

1. Five members, one of whom must be an allopathic or osteopathic physician, one of whom must be an executive in the business community, one of whom must be a hospital administrator, one of whom must be a certified public accountant, and one of whom must be a member of The Florida Bar, all of whom must actively practice or work in this state.

2. Three members selected from a list of persons

recommended by the President of the Senate who practice allopathic or osteopathic medicine or who are patient advocates. At least one member must be an allopathic or osteopathic physician, and at least one member must be a patient advocate. All three members must be in active practice or reside in this state.

3. Three members selected from a list of persons recommended by the Speaker of the House of Representatives who practice allopathic or osteopathic medicine or who are patient advocates. At least one member must be an allopathic or osteopathic physician, and at least one member must be a patient advocate. All three members must be in active practice or reside in this state.

(b) *Terms of appointment.*—Members are appointed to 4-year terms. For the purpose of providing staggered terms, of the initial appointments, the five members appointed pursuant to subparagraph 1. shall be appointed to 2-year terms, and the remaining six members pursuant to subparagraphs 2. and 3. shall be appointed to 3-year terms. If a vacancy occurs on the board before the expiration of a term, the Governor shall appoint a successor to serve the remainder of the term.

(c) *Chair and vice chair.*—The board shall annually elect from its membership a chair of the board and a vice chair.

(d) *Meetings.*—The first meeting of the board must be held no later than August 1, 2015. Thereafter, the board must meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, web conference, or other electronic means.

(e) *Compensation.*—Members of the board serve without

compensation but may be reimbursed for per diem and travel expenses for required attendance at board meetings in accordance with s. 112.061.

(f) *Powers and duties of the board.*—The board has the following powers and duties:

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

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

3. Employing an executive director and other staff as necessary to perform the functions of the Patient Compensation System, except that the Governor appoints the initial executive director.

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

5. Approving a schedule of compensation for medical injuries, as recommended by the compensation committee.

6. Approving medical review panelists as recommended by the medical review committee.

7. Approving an annual budget.

8. Annually approving provider contribution amounts.

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

1. Advocacy director.—The advocacy director shall ensure that each applicant is provided high quality individual assistance throughout the process, from initial filing to

disposition of the application. The advocacy director shall assist each applicant in determining whether to retain an attorney, which assistance shall include an explanation of possible fee arrangements and the advantages and disadvantages of retaining an attorney. If the applicant seeks to file an application without an attorney, the advocacy director shall assist the applicant in filing the application. In addition, the advocacy director shall regularly provide status reports to the applicant regarding his or her application.

2. Chief compensation officer.—The chief compensation officer shall manage the Office of Compensation. The chief compensation officer shall recommend to the compensation committee a compensation schedule for each type of medical injury. The chief compensation officer may not be a licensed physician or an attorney.

3. Chief financial officer.—The chief financial officer is responsible for overseeing the financial operations of the Patient Compensation System, including the annual development of a budget.

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

5. Chief medical officer.—The chief medical officer must be a physician licensed under chapter 458 or chapter 459 and shall manage the Office of Medical Review. The chief medical officer shall recommend to the medical review committee a qualified list

of multidisciplinary panelists for independent medical review panels. In addition, the chief medical officer shall convene independent medical review panels as necessary to review applications.

6. Chief quality officer.—The chief quality officer shall manage the Office of Quality Improvement.

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

(a) *Office of Medical Review.*—The Office of Medical Review shall evaluate and, as necessary, investigate all applications in accordance with this part. For the purpose of an investigation of an application, the office has the power to administer oaths, take depositions, issue subpoenas, compel the attendance of witnesses and the production of papers, documents, and other evidence, and obtain patient records if the patient consents.

(b) *Office of Compensation.*—The Office of Compensation shall allocate compensation for each application in accordance with the compensation schedule adopted pursuant to subparagraph (2)(f)5.

(c) *Office of Quality Improvement.*—The Office of Quality Improvement shall regularly review application data to conduct root cause analyses and develop and disseminate best practices based on the reviews. In addition, the office shall capture and record safety-related data obtained during an investigation conducted by the Office of Medical Review, including the cause of, the factors contributing to, and any interventions that may have prevented the medical injury.

(4) COMMITTEES.—The board shall create a medical review

committee and a compensation committee. The board may create additional committees as necessary to assist in the performance of its duties and responsibilities.

(a) *Members.*—Each committee consists of three board members chosen by a majority vote of the board.

1. The medical review committee is composed of two physicians and a member who is not an attorney. The board designates one of the physician members as chair of the committee.

2. The compensation committee is composed of a certified public accountant and two members who are not physicians or attorneys. The certified public accountant serves as chair of the committee.

(b) *Terms of appointment.*—Members of each committee are appointed to 2-year terms concurrent with their respective terms as board members. If a vacancy occurs on a committee, the board shall appoint a successor to serve the remainder of the term. A committee member who is removed or resigns from the board must be removed from the committee.

(c) *Chair and vice chair.*—The board shall annually designate a chair, pursuant to paragraph (a), and a vice chair of each committee.

(d) *Meetings.*—Each committee must meet at least quarterly and at the specific direction of the board. Meetings may be held by teleconference, web conference, or other electronic means.

(e) *Powers and duties.*—

1. The medical review committee shall recommend to the board a comprehensive, multidisciplinary list of panelists who are eligible to serve on the independent medical review panels

as needed.

2. The compensation committee shall, in consultation with the chief compensation officer, recommend to the board:

a. A compensation schedule, formulated such that the aggregate cost of medical malpractice and the aggregate of provider contributions are equal to or less than the prior fiscal year's aggregate cost of medical malpractice. Thereafter, the committee shall annually review the compensation schedule and, if necessary, recommend a revised schedule, such that a projected increase in the upcoming fiscal year's aggregate cost of medical malpractice, including insured and self-insured providers, does not exceed the percentage change from the prior year in the medical care component of the Consumer Price Index for All Urban Consumers published by the United States Department of Labor.

b. Guidelines for the payment of compensation awards through periodic payments.

c. Guidelines for the apportionment of compensation among multiple providers, which guidelines shall be based on the historical apportionment among multiple providers for similar injuries with similar severity.

(5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical officer shall convene an independent medical review panel to evaluate each application to determine whether a medical injury occurred. Each panel shall be composed of an odd number of at least three panelists chosen from a list of panelists representing the same or similar specialty as the provider who is the subject of the application. The panel shall convene, either in person or by teleconference, upon the call of the

chief medical officer. Each panelist shall be paid a stipend as determined by the board for his or her service on the panel. In order to expedite the review of applications, the chief medical officer may, whenever practicable, group related applications together for consideration by a single panel.

(6) CONFLICTS OF INTEREST.—A board member, panelist, or employee of the Patient Compensation System may not engage in any conduct that constitutes a conflict of interest. For purposes of this subsection, the term "conflict of interest" means a situation in which the private interest of a board member, panelist, or employee could influence his or her judgment in the performance of his or her duties under this part. A board member, panelist, or employee must immediately disclose in writing the existence of a conflict of interest when the board member, panelist, or employee knows or should reasonably know that the factual circumstances surrounding a particular application constitutes a conflict of interest. A board member, panelist, or employee who violates this subsection is subject to disciplinary action as determined by the board. A conflict of interest includes, but is not limited to:

(a) Conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a board member, panelist, or employee is biased against or in favor of an applicant.

(b) Participation in an application in which the board member, panelist, or employee, or the parent, spouse, or child of a board member, panelist, or employee, has a financial interest.

(7) RULEMAKING.—The board shall adopt rules to implement

and administer this part, including rules addressing:

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

(b) Disciplinary procedures for a board member, panelist, or employee who violates subsection (6).

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

(d) Payment of compensation awards through periodic payments and the apportionment of compensation among multiple providers, as recommended by the compensation committee.

(e) An opt-out process for providers who do not want to participate in the Patient Compensation System.

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

766.405 Filing of applications.—

(1) CONTENT.—In order to obtain compensation for a medical injury, an applicant or his or her legal representative must file an application with the Patient Compensation System. The application must include the following:

(a) The name and address of the applicant or his or her legal representative, and the authority under which the representative is acting on behalf of the applicant.

(b) The name and address of any participating provider who provided medical treatment that allegedly gave rise to the medical injury.

(c) A brief statement of the facts and circumstances surrounding the medical injury which gave rise to the

application.

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

(e) Any other information that the applicant believes will be beneficial to the investigatory process, including the names of potential witnesses.

(f) Documentation of any applicable private or governmental source of services or reimbursement relative to the medical injury.

(2) INCOMPLETE APPLICATIONS.—If an application is incomplete, the Patient Compensation System shall notify the applicant in writing, within 30 days after the receipt of the initial application, of any errors or omissions. An applicant has 30 days after receipt of the notice in which to correct the errors or omissions in the initial application.

(3) TIME LIMITATION ON APPLICATIONS.—An application must be filed within the time periods specified for medical malpractice actions in s. 95.11(4)(b). The applicable time period is tolled from the date of the filing of an application until the date of the receipt by the applicant of the results of the initial medical review under s. 766.406.

(4) SUPPLEMENTAL INFORMATION.—After the filing of an application, the applicant may supplement the initial application with additional information that the applicant believes may be beneficial in the resolution of the application.

(5) LEGAL COUNSEL.—This part does not prohibit an applicant or participating provider from retaining an attorney to represent the applicant or participating provider in the review

and resolution of an application.

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

766.406 Disposition of applications.—

(1) INITIAL MEDICAL REVIEW.—Individuals with relevant clinical expertise in the Office of Medical Review shall, within 10 days after the receipt of a completed application, determine whether the facts stated in the application give rise to a prima facie claim for medical injury.

(a) If the Office of Medical Review determines that the facts stated in the application give rise to a prima facie claim for medical injury, the office shall immediately notify by registered or certified mail each participating provider named in the application and, for participating providers that are not self-insured, the insurer that provides coverage to the provider. The notification shall inform the participating provider that he or she may support the application to expedite the processing of the application. A participating provider has 15 days after the receipt of notification of an application to support the application. If the participating provider supports the application, the Office of Medical Review shall review the application in accordance with subsection (2).

(b) If the Office of Medical Review determines that the facts stated in the application do not give rise to a prima facie claim for medical injury, the office shall send a rejection letter to the applicant by registered or certified mail informing the applicant of his or her right to appeal. The applicant has 15 days after the receipt of the letter in which to appeal the determination of the office pursuant to s.

766.407.

(2) EXPEDITED MEDICAL REVIEW.—An application that is supported by a participating provider in accordance with subsection (1) shall be reviewed by individuals with relevant clinical expertise in the Office of Medical Review within 30 days after notification of the participating provider's support of the application to determine the validity of the application. If the Office of Medical Review finds that the application is valid, the Office of Compensation shall determine an award of compensation in accordance with subsection (4). If the Office of Medical Review finds that the application is not valid, the office shall immediately notify the applicant of the rejection of the application and, in the case of fraud, shall immediately notify relevant law enforcement authorities.

(3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review determines that the facts stated in the application give rise to a prima facie claim for medical injury and the participating provider does not elect to support the application, the office shall complete a thorough investigation of the application within 60 days after the initial determination. The investigation shall be conducted by a multidisciplinary team with relevant clinical expertise and must include a thorough investigation of all available documentation, witnesses, and other information. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the participating provider to access records, statements, and other information obtained in the course of its investigation, in accordance with relevant state and federal laws.

(a) Within 30 days after the completion of the investigation, the chief medical officer shall convene an independent medical review panel to determine whether the facts stated in the application give rise to a claim for medical injury. The independent medical review panel must have access to all information, including information that was previously redacted, which was obtained by the office in the course of its investigation of the application. The panel shall complete its review and make a written determination within 10 days after convening. The panel's written determination shall be immediately provided to the applicant and the participating provider.

(b)1. If the panel determines that the medical intervention conformed to national practice standards for the care and treatment of patients, the application shall be dismissed and the provider may not be held responsible for the patient's medical injury.

2. The panel shall report that the facts stated in the application support the claim for medical injury if it determines by a preponderance of the evidence that the following criteria are met:

a. The provider performed a medical service on the applicant;

b. The applicant suffered a personal injury or death;

c. The medical service was the proximate cause of the personal injury or death; and

d. One or more of the following, as determined in accordance with s. 766.402(9):

(I) An accepted method of medical services was not used for

treatment.

(II) An accepted method of medical services was used for treatment, but was executed in a substandard fashion.

(III) An accepted method was used, but, the personal injury or death could have been avoided by using a less invasive, but equally or more effective, treatment.

(c) If the independent medical review panel determines that the facts stated in the application support the claim for medical injury, the Office of Medical Review shall immediately notify the participating provider by registered or certified mail of the right to appeal the determination of the panel. The participating provider has 15 days after the receipt of the letter in which to appeal the determination of the panel pursuant to s. 766.407.

(d) If the independent medical review panel determines that the facts stated in the application do not support the claim for medical injury, the Office of Medical Review shall immediately notify the applicant by registered or certified mail of his or her right to appeal the determination of the panel. The applicant has 15 days after the receipt of the letter to appeal the determination of the panel pursuant to s. 766.407.

(4) COMPENSATION REVIEW.—If an independent medical review panel finds that the facts stated in an application support the claim for medical injury under subsection (3) and all appeals of that finding have been exhausted by the participating provider pursuant to s. 766.407, the Office of Compensation shall, within 30 days after the later of the finding of the panel or the exhaustion of all appeals make a written determination of an award of compensation in accordance with the compensation

schedule and the findings of the panel. The office shall notify the applicant and the participating provider by registered or certified mail of the amount of compensation and shall explain to the applicant the process for appealing the award of compensation. The applicant has 15 days after the date of receipt of the letter to appeal the award as provided in s. 766.407.

(5) LIMITATION ON COMPENSATION.—Compensation for damages must be offset by any past and future collateral source payments. In addition, compensation may be paid by periodic payments as determined by the Office of Compensation in accordance with rules adopted by the board.

(6) PAYMENT OF COMPENSATION.—Within 14 days after the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.407, the participating provider or, for a participating provider who has insurance coverage, the insurer must remit the compensation award to the Patient Compensation System, which must immediately provide compensation to the applicant in accordance with the final compensation award. Beginning the later of 45 days after the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.407, an unpaid award begins to accrue interest at the rate of 18 percent per year.

(7) DETERMINATION OF MEDICAL MALPRACTICE.—The findings issued under this part do not constitute a finding of medical malpractice for purposes of s. 26, Art. X of the State Constitution.

(8) PROFESSIONAL BOARD NOTICE.—The Patient Compensation System shall provide the department with electronic access to

applications that lead to a determination that a medical injury occurred when they involve health care providers licensed under chapter 458, chapter 459, chapter 460, part I of chapter 464, or chapter 466, if the Patient Compensation Trust Fund determines that the provider presents an imminent risk of harm to the public. The department shall review these applications to determine whether any of the incidents that resulted in the application potentially involve conduct by the licensee which is subject to disciplinary action, in which case s. 456.073 applies.

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

766.407 Review by administrative law judge; appellate review; extensions of time.—

(1) REVIEW BY ADMINISTRATIVE LAW JUDGE.—An administrative law judge shall hear and determine appeals filed pursuant to s. 766.406 and shall exercise the full power and authority granted to him or her in chapter 120, as necessary, to carry out the purposes of that section. The administrative law judge shall be limited in his or her review to determining whether the Office of Medical Review, the independent medical review panel, or the Office of Compensation, as appropriate, has faithfully followed the requirements of this part, and rules adopted thereunder, in reviewing applications. If the administrative law judge determines that the requirements were not followed in reviewing an application, he or she shall require the chief medical officer to reconvene the original panel or convene a new panel, or require the Office of Compensation to redetermine the compensation amount in accordance with the determination of the

judge.

(2) APPELLATE REVIEW.—A determination by an administrative law judge under this section regarding the award or denial of compensation under this part shall be conclusive and binding as to all questions of fact and shall be provided to the applicant and the participating provider. An applicant may appeal the award or denial of compensation to the district court of appeal. Appeals shall be filed in accordance with rules of procedure adopted by the Supreme Court for review of such orders.

(3) EXTENSIONS OF TIME.—Upon a written petition by either the applicant or the participating provider, an administrative law judge may grant, for good cause, an extension of any of the time periods specified in this part. The relevant time period is tolled from the date of the written petition until the date of the determination by the administrative law judge.

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

766.408 Expenses of administration; opt out.—

(1) The board shall annually determine the required contribution of each participating provider in the Patient Compensation System. The required contribution amount shall be determined by January 1 of each year based on the anticipated expenses of the administration of this part for the next state fiscal year.

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

(a) For an individual with certification or recertification under section 401.27, a chiropractic assistant licensed under chapter 460, or, with the exception of health care providers

specified in paragraph (b), an individual licensed under chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 467, part I, part II, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468, chapter 478, part III of chapter 483, or chapter 486, $100 per licensee.

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

(c) For a physician licensed under chapter 458, chapter 459, or chapter 460, $600 per licensee. The contribution for the initial fiscal year shall be $500 per licensee.

(d) For a facility licensed under part II of chapter 400, $100 per bed.

(e) For a facility licensed under chapter 395, $200 per bed, except that the required contribution for the initial fiscal year is $100 per bed.

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

(3) The required contribution determined under this section is payable by each participating provider within 30 days after the date the notice of the required contribution is delivered to the provider. If a participating provider fails to pay the required contribution within 30 days after delivery of the initial notice, the board shall notify the provider by certified or registered mail that the provider's license is subject to revocation if the required contribution is not paid within 60 days after the date of the original notice.

(4) A provider who does not opt out of participation

pursuant to subsection (6) and who fails to pay the required contribution amount determined under this section within 60 days after receipt of the original notice shall be subject to a licensure revocation action or discipline by the department, the Agency for Health Care Administration, or the relevant regulatory board, as applicable.

(5) All amounts collected under this section shall be paid into the Patient Compensation Trust Fund established in s. 766.412.

(6) A provider may elect to opt out of participation in the Patient Compensation System. The election to opt out must be made in writing no later than 15 days before the due date of the contribution required under this section. A provider who opts out may subsequently elect to participate by paying the appropriate contribution amount for the current fiscal year.

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

766.409 Notice to patients of participation in the Patient Compensation System.—

(1) Each participating provider must provide notice to patients that the provider is participating in the Patient Compensation System. The notice shall be provided on a form furnished by the Patient Compensation System and shall include a concise explanation of a patient's rights and benefits under the system.

(2) Notice is not required to be given to a patient when the patient has an emergency medical condition, with respect to a pregnant woman, as defined in s. 395.002(8)(b) or when notice is not practicable.

Section 12. Section 766.411, Florida Statutes, is created to read:

766.411 Annual report.—Beginning on October 1, 2017, the board shall annually submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that describes the filing and disposition of applications in the preceding fiscal year. The report shall include, in the aggregate, the number of applications, the disposition of such applications, and the compensation awarded.

Section 13. This act applies to medical incidents for which a notice of intent to initiate litigation has not been mailed before July 1, 2016.

Section 14. This act shall take effect July 1, 2016.